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ABSTRACT

This special journal "Theme" issue presents a collection of papers reflecting the psychiatric practices and community treatment for persons with severe psychiatric disabilities in Asia, Africa, Australia, and India. Some of the papers were presented at the 1988 meeting of the World Association of Psychosocial Rehabilitation (WAPR) in Lyons, France. Compared to technologically advanced nations of the West, the developing nations' approach is characterized by more efficient utilization of scarce resources, culturally syntonic diagnostic and treatment procedures that merge indigenous healing systems with scientific modalities, and the inclination of most third world practitioners to integrate the patients' families into the healing process. Papers include: "Rehabilitation in Mental Illness: Insights from Other Cultures" (Harriet P. Lefley); "Report of a World Health Organization (WHO) Meeting on Consumer Involvement in Mental Health Services"; "Psychosocial Rehabilitation in the Developing World: Progress and Problems" (M. Parameshvara Deva); "An Example of a Community Based Mental Health/Home-Care Programme: Haidian District in the Suburbs of Beijing, China" (Shen Yucun and others); "Nigeria: Report on the Care, Treatment and Rehabilitation of People with Mental Illness" (Tolani Asuni); "A Model for the Care of People with Psychosocial Disabilities in Sri Lanka" (Nalaka Mendis); "Integration of Psychosocial Rehabilitation in National Health Care Programmes" (Vijay Nagaswami); and "Rural Psychiatric Rehabilitation and the Interface of Community Development and Rehabilitation Services" (Douglas A. Dunlap.) (JDD)

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49

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2

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Table of Contents

Special Issue: Psychosocial Rehabilitation and Mental Illness: Views from Africa, India, Asia, and Australia

1 Introduction
Diane E. Woods

3 Guest Editorial
Marianne Farkas and Ruth Hughes

5 Rehabilitation in Mental Illness: Insights from Other Cultures
Harriet P. Lefley

13 Report of a World Health Organization (WHO) Meeting On Consumer Involvement in Mental Health Services

21 Psychosocial Rehabilitation in the Developing World: Progress and Problems
M. Parameshvara Deva

29 An Example of a Community Based Mental Health/ Home-Care Programme: Haidian District in the Suburbs of Beijing, China
Shen Yucun, Chen Changhui, Zhang Weixi, Xi Tingming, and Tian Yunhua

35 Nigeria: Report on the Care, Treatment and Rehabilitation of People with Mental Illness
Tolani Asuni

45 A Model for the Care of People with Psychosocial Disabilities in Sri Lanka
Nalaka Mendis

(Continued)

Table of Contents (Continued)

53 Integration of Psychosocial Rehabilitation in National Health Care Programmes
Vijay Nagaswami

67 Rural Psychiatric Rehabilitation and the Interface of Community Development and Rehabilitation Services
Douglas A. Dunlap

91 Book Reviews

97 Monograph Series

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Introduction

This issue of the Journal of Psychosocial Rehabilitation began as a compilation of papers from several countries, some of which had been presented in 1988 at a World Association of Psychosocial Rehabilitation (WAPR) meeting held in Lyon, France. In conjunction with that meeting, an Advanced Institute on Psychosocial Rehabilitation was convened. This was a strategy meeting designed to develop relevant mental health programs in emerging countries. Thanks to Martin Gittleman, the program chair of WAPR, the World Rehabilitation Fund (WRF)—International Exchange of Experts and Information in Rehabilitation (IEEIR) was able to obtain some very interesting papers from that Institute for future publication.*

Somewhat later, an IEEIR fellowship award was made to Dr. Douglas Dunlap to investigate community and family approaches to rehabilitation of people with severe and persistent mental health problems in India and Australia. We decided to include Dr. Dunlap's fellowship report as a part of the IEEIR monograph on Psychosocial Rehabilitation.

Although the IEEIR monograph series has been reserved mainly for foreign authors, nonetheless, there have been occasions when selected fellowship experiences have been included in the series. It certainly seemed appropriate to include Dr. Dunlap's report as contribution to this monograph.

Dr. Dunlap was recommended as a potential fellow who could contribute significantly to the IEEIR fellowship program, by Marianne Farkas, Director of Training for the Center for Psychiatric Rehabilitation at Boston University.

Since the Center for Psychiatric Rehabilitation and IAPSRS co-publish the Psychosocial Rehabilitation Journal, it was decided to explore the possibility of joining with them to co-publish an issue of the Journal. LeRoy Spaniol and Ruth Hughes agreed to join forces with the International Exchange of Experts and Information in Rehabilitation to co-publish a special international issue on psychosocial rehabilitation in the developing world.

The National Institute for Disability and Rehabilitation Research (NIDRR) has been very supportive of the efforts of the IEEIR. It is through NIDRR's support that the IEEIR has been able to produce fifty publications and award 150 fellowships over the past twelve years.

Diane E. Woods, Project Director
International Exchange of Experts
and Information in Rehabilitation

**Permission has been given by the authors for publication of their edited articles in this special issue of the Psychosocial Rehabilitation Journal.*

PSYCHOSOCIAL REHABILITATION JOURNAL

Special Issue

Volume 13, No. 4, April, 1990

SUPPORTED HOUSING: NEW APPROACHES TO RESIDENTIAL SERVICES

Sample of Contents

Guest Editorial
A Home Not Housing
Thomas Posey

Supported Housing: A Critical Component of Effective Community Support
Jacqueline Parrish

The Paradigm Shift in Residential Services From the Linear Continuum to Supported Housing Approaches
Priscilla Ridgway and Anthony M. Zipple

Responding to Consumer Housing Preferences: The Toledo Experience
Jonathan Keck

Supported Housing for the Most Disabled: Suggestions for Providers
Mary Alice Brown and Thomas Wheeler

A Comprehensive Approach to Residential Services for and with People with Serious Mental Illness
Grady O'Rear and Tena Meadows O'Rear

Independent Living with Support Services: The Goal and Future for Mental Health Consumers
Howie the Harp

The Relationship Between Residential Treatment and Supported Housing in a Community System of Services
Steve Fields

Developing Housing for the Homeless
Paula Goering, Janet Durbin, John Trainor and Darianna Paduchak

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Guest Editorial

This issue of the Psychosocial Rehabilitation Journal is an exciting collection of articles reflecting the practices and community treatment for persons with severe psychiatric disabilities in Asia, Africa, Australia and India, and gives North American and European practitioners some food for thought. It is the result of the collaborative effort of the World Rehabilitation Fund—International Exchange of Experts and Information in Rehabilitation, the Center for Psychiatric Rehabilitation at Boston University and the International Association of Psychosocial Rehabilitation Services.

In North America and Europe, our efforts to provide effective psychiatric rehabilitation are too often molded by needs to conform to existing systems of institutional care. Even when our efforts are to reduce the populations in mental institutions, and to recreate community systems of care and support, we are doing so from a professional, educational and economic position which is strongly biased towards institutions.

As North Americans, therefore, it is interesting for us to read accounts of efforts in Asia and Africa which are well grounded in the natural community systems of support that we are only now trying to recreate. Many of the societies reflected in this issue could not afford to be hospital based systems. They do not face the perplexing problems North America and Europe face of trying to phase down hospital resources while building up community systems. Nor are they engaged in a struggle with consumers, family members and community groups in quite the same way as we are. As Harriet Lefly points out, the integration and interdependence of clients and care givers with extended families and the natural community supports in the 'sina qua non' of mental health and rehabilitation efforts in China, India and Africa. The role of traditional healers in India and Africa, the development of a cadre of barefoot doctors in China and the use of supportive workers in ASEAN countries are all examples of how to use a few professionals with indigenous support systems that are culturally responsive.

To be truly integrated into community life, means having a productive and useful role. In many countries, work is considered an essential part of the therapeutic process in both the hospital and community, without the artificial barriers and disincentives which have developed in the US system. In rural societies, there are frequently more opportunities for low stress, productive jobs, a tolerance for unusual behavior, and an expectation that each of us contribute to the community welfare. The Chinese view of work as a measure of outcome is already an integral part of the community rehabilitation process. Work figures strongly in the rehabilitation efforts of other regions as well.

That is not to say that the systems in these countries are perfect and that those of us struggling in Europe and North America should attempt to copy these systems. The countries represented in this issue are also experiencing great difficulties—a serious lack of resources, large numbers of persons in need, immense territories with poor transportation and few professional services available. We find, however, that we may have much to learn from the extensive experiences of these countries in delivering community based services, involving families and indigenous supports, utilizing a small number of professionals and including work as a natural part of the entire rehabilitation spectrum.

And what do we have to offer? While we may not be able to make comparisons at the systems level because of the vast differences in our societies and financial resources, we may well have useful techniques and approaches to psychiatric rehabilitation that are worth sharing. The rich array of psychosocial rehabilitation approaches developed in North America and Europe may be of potential usefulness to Asian and African nations. The world is shrinking so quickly that we may soon find that our commonalities far outweigh our differences. Let us hope that we, in rehabilitation, have the wisdom to learn from the best that each continent has developed, so that persons with psychiatric disabilities can be fully integrated into the community life, whatever its configuration and wherever it is located in the world.

Marianne Farkas, Director of International Rehabilitation, Center for Psychiatric Rehabilitation, Boston, Massachusetts USA

Ruth Ann Hughes, Executive Director, International Association of Psychosocial Rehabilitation Services, Columbia, Maryland USA

Rehabilitation in Mental Illness: Insights from Other Cultures

Harriet P. Lefley, Ph.D.

Dr. Lefley is Professor of Psychiatry at the University of Miami

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It has been over a decade since the International Pilot Study of Schizophrenia (IPSS) confirmed earlier findings that persons with major psychotic disorders have a more benign course of illness in the developing nations than in the technologically advanced societies of the west (World Health Organization, 1979). The papers in this book begin to tell us why.

Despite our quantitative advantages in funding, facilities, and professional personnel, when westerners look at the ways in which third world countries deal with major mental illnesses, several areas of relative strength become apparent. First is the more efficient utilization of scarce resources, with providers sometimes offering home services which are increasingly unavailable in most of the clinic-based systems of the industrialized countries. Second is the culturally syntonic diagnostic and treatment procedure that merges indigenous healing systems, or modes of service provision, with scientific modalities. Third, and perhaps most important, is the inclination of *most third world practitioners to welcome and integrate the patients' natural support systems—their families—into the healing process.*

Interrelatedly, the artificial distinction between "cure" and "care" in western thinking (Gittelman, 1978), which has dichotomized clinical and rehabilitative services, seems to be irrelevant in most third world systems. Integrated medical and mental health services, which we have rediscovered as the "linkage model" (Broskowski, Marks, & Budman, 1981), and case management as a necessary feature of rehabilitation, are concepts long incorporated in the more fluid and less compartmentalized systems of the developing countries. This is a unified mode of thinking to which we are just now beginning to return in the United States.

It should be emphasized that there is no intention of romanticizing the necessarily limited services of third world countries when compared with those of the affluent west. Yet, the planning process and the training of skilled paraprofessionals facilitate some efforts from which westerners could learn a great deal. For example, the field survey for the "community mental health care net" described by Shen Yucun in a Chinese population of 190,000—about the size of one of our community mental health center catchment areas—seems more direct and efficient than our customary needs assessments. With greater resources, we nevertheless target estimated percentages of at-risk populations rather than identified individuals in need of mental health care. Psychiatric interviews of such potential clients would seem an extraordinary luxury in the more affluent United States. The fact that site casefinding and psychiatric evaluation can be done in a relatively poor country suggests that our mental health costs may be vastly inflated.

Precisely because of their poverty, third world nations have had to attend first to the most needful population: the severely and persistently mentally ill. In the United States, community mental health centers have typically expanded the parameters of mental health services and the universe of potential consumers, well beyond those with psychotic illnesses or even DSM-defined disorders. Reviews of the research literature indicate that for many years the centers tended to underserve the deinstitutionalized chronic patients whose needs they were intended to meet (Bachrach, 1983; Lefley, 1984). Our professional training programs in the four core disciplines may or may not involve a brief internship with seriously mentally ill persons in the public sector; but most graduates will elect to do private practice with clients with lesser disorders, often focusing on those who have been termed "demoralized," or "merely unhappy." In fact, many psychotherapists apply their years of training to work with well-functioning individuals who are simply seeking growth and self-actualization. In terms of societal use of scarce and valuable resources, the ratio of skills to need seems to be both more equitable and more rational in the third world.

The paper by Asuni describes the role of traditional healers in Nigeria. Erinosho (1979) had previously suggested that, regardless of individual orientation, all of Nigerian psychiatry recognizes cultural conceptions of mental illness and the diagnostic procedures, herbs, and symbolic rituals used in folk healing. In the United States and in many European countries, continuing immigration of culturally diverse peoples requires a similar acknowledgment and respect for their belief systems and traditional therapeutic practices. In our own program in multi-ethnic Miami, as well as elsewhere in the United States, traditional healing has often been integrated with clinical treatment programs in an effort to offer interventions that were most likely to be acceptable and comprehensible to clients from other cultures (Lefley, 1984; Lefley & Bestman, 1984). Families of course have a critical role in all interventions, traditional and otherwise. They are the ongoing support system, the single major source of care and concern for the patient. As Asuni points out, patients cannot be treated in isolation from persons who are significant in their lives. During hospitalization, if relatives are not involved from the very beginning, it is difficult for them to know how to accept responsibility at discharge. This is a truism which we are just now beginning to accept in the west. The training of new generations of clinicians is beginning to focus on working in a collaborative model with families of the mentally ill (Lefley, 1988).

In the U.S., the history of relations between professionals and families has vacillated between excluding the family altogether, or propelling family members into unrequested family therapy that does not seem congruent with their needs. This has resulted in documented dissatisfaction with services (Holden & Lewine, 1982) and often iatrogenic guilt (Terkelsen, 1983). This has rarely been the case in the third world, where it would be incongruous *not* to involve the family in discussions and decisions regarding the patient's health.

Throughout the cross-cultural literature, it is apparent that in third world countries families are seen as an essential resource in patient care and rehabilitation (Lefley 1985). There has always been some emphasis on family education, in contrast to the arcane therapies in the United States that seem to ignore families' expressed needs for illness management and coping skills in living with these difficult disorders. It is only recently that we have seen the development of interventions that satisfy families' requests for education about the illnesses, behavior management and problem-solving techniques, and compassionate understanding of their profound sorrow and distress. These include the supportive counseling model of Bernheim and Lehman (1985) and the carefully researched psychoeducational models of Anderson, Reiss and Hogarty (1986), and Falloon, Boyd, & McGill (1984). Educational packages for families have been developed also by professionals associated with the National Alliance for the Mentally Ill (Hatfield, 1983).

Yet this reasonable and empirically-supported educational approach continues to be rejected by many systems-oriented family therapists. Some repudiate medication and/or still believe psychotic symptoms stem not from disordered neurotransmitters, but from a need to maintain homeostasis in the family system through bizarre or antisocial behavior (Haley, 1988, Selvini-Palazolli, 1987). The efficacy of their work has never been demonstrated in research, whereas the psychoeducational approaches of Anderson (*op cit*) and Falloon (*op cit*) have led to documented reductions in relapse rates. Other systems therapists have now developed a family consultation approach (Wynne, McDaniel & Weber, 1986). This is a more direct and non-dissembling intervention which respects the presenting needs of families within their own conceptual framework—an approach long advocated in cross-cultural service provision (Lefley, 1984).

The American system in particular sets up a number of barriers between patients and families. Developing countries do not seem to share our worship of it confidentialy, which initially derived from the now-discredited notion of family pathogenesis. The curative patient-therapist alliance had the ultimate aim of separating the patient from the dysfunctional family unit, an objective congruent with the western core value of independence, but discordant with a cultural value of interdependence. Third world psychiatrists apparently feel free to ask the patient to leave the room so they can talk to relatives, who are perceived as a source of authentic information, and always seem to view relatives as allies, not adversaries. In recent years we have begun to replace the pathogenic model with a paradigm of coping and adaptation, focusing on families' strengths in coping with lives of inordinate pain and stress (Hatfield & Lefley, 1987).

Much of the strength of relatives in the rehabilitative process derives from the sustenance that they themselves may muster from others in dealing with these devastating and draining illnesses. Interpretations of the IPSS findings of more benign course of schizophrenia in the developing countries generally have focused on a few speculative variables. Among these are the extended or joint family system, with its more extensive supports and buffering mechanisms for diffusing family burden (Leff, 1981). There is some evidence from India that the joint family system is beginning to erode with increasing urbanization (Sethi *et al*, 1987). The literature on expressed emotion (EE) showed a correlation between criticalness and overinvolvement (high EE) of some family members and patients' relapse rates in numerous replications (Vaughn *et al*, 1984). This has been attributed to the toxic effects of overstimulation on persons with the core biological deficits of schizophrenia, and the investigators state that this may come from any environmental source, not just families (*ibid*). IPSS followup studies on stressful life events have demonstrated that a range of environmental stressors may precipitate relapse among patients in numerous countries throughout the world, regardless of level of development (Day et al, 1987).

Research has shown that high EE is relatively rare in third world countries, reconfirmed in recent studies in India (Wig *et al*, 1987). It has been suggested that patients may do better in the developing countries because there are more kinship networks, more buffering mechanisms, and apparently greater equanimity with respect to tolerance of difficult behaviors. For patients, there are also more opportunities for low-stress, non-competitive productive roles in communal societies and agrarian economics.

The paper by Shen Yucun and associates depicts involvement of patients in "the normal activities of the collective" in the Haidian District near Beijing, China. These are considered essential correlates of clinical care. Indeed, we find greater possibilities for this normalization process throughout the third world, and particularly in countries where there is centralized planning of mental health services. Many countries continue to have hospital-based industries which provide training and often payment for patients in meaningful work. Others develop innovative vocational rehabilitation programs, or sheltered workshops with light industrial assembly work done on a contract basis, as described by Dr. Deva. In the United States, hospital work has largely been phased out, and sheltered workshops are geared primarily toward training the developmentally disabled or mentally retarded client. There are few vocational opportunities for persons with good intelligence who may have a high level of residual skills but impaired concentration or attention span.

Perhaps the most significant lesson we have to learn is the humane potential and organizational advantages of a national health insurance system, or as in the ASEAN nations, free medical and mental health care as a natural contribution of government to its citizens. The United States continues to have a two-tiered system of care, private and public, for rich and not-rich, the latter including many middle class patients. Skyrocketing costs of psychiatric care together with limits on private insurance insure that ultimately, almost all chronic patients end up in the public sector. Almost all community support services are in the public sector, including psychosocial rehabilitation programs.

As Dr. Deva notes, developing countries do not have the half-way housing or case management services now available in many urban (not rural) areas of the United States. In the third world, the service delivery systems still depend on the families for housing, economic sustenance, and caregiving. Yet the lack of adequate community support services in the United States, particularly residential facilities, continues to be a national disgrace. In countries based on a nuclear family structure, home care for persons with long-term mental illnesses can be destructive to the psychological and physical health of the caregivers. This is particularly draining on the energies of aging parents who take care of psychotic adult children, and of course, are likely to be outlived by them. In the United States, almost 40% of deinstitutionalized patients seem to live in such households (Lefley, 1987).

The National Alliance for the Mentally Ill (NAMI), an organization composed primarily of families of long-term mentally ill persons, has grown at an astonishing rate since its inception in 1979. Dedicated to advocacy, education, mutual support, and resource development, NAMI has become extremely influential at national, state, and local levels in legislative advocacy for services as well as for basic research on the major psychotic disorders. Although there are now family movements in other countries, they have progressed slowly in comparison with NAMI's phenomenal growth in the United States. This growth may well be related to the greater pressure on families where there are at most two parents, frequently only one, to care for a chronic adult and few siblings have been enculturated to accept this role as their responsibility. Where there are no extended kinship networks, caregiving of highly disturbed persons with distressing positive or negative symptoms becomes highly maladaptive to the caregivers, unless there are compensatory supports (Hatfield & Lefley, 1987). The local AMI affiliates often become surrogate kinship networks, providing the psychological and social supports of persons bonded by mutual problems and sorrows.

Although NAMI groups have actively developed resources to fill in gaps in the service delivery system, such as housing, sheltered workshops, and psychosocial rehabilitation programs, families have multiple obligations to other members and most feel that it is government's responsibility to provide for its disabled citizens. Above all, family members are increasingly unwilling to fulfill an extremely difficult caregiving role at home. In the United States, with its emphasis on personal autonomy, permanent responsibility for a chronic patient is destructive to the career or marriage options of caregivers (typically females) and to the independent functioning of the patients themselves. To make this clear, our surveys show that most families prefer not a day-to-day caregiving role, but one of ongoing support system to the patient and adjunctive resource to the mental health system, including case management as needed (Lefley, 1987). For this, many family members want advice and training from professionals. An increasing number of agencies now offer support groups and psychoeducational classes to families, and many of our continuing education workshops focus on training practitioners for this role.

As third world countries move toward greater industrialization and the inevitable erosion of the joint family, the need for community support systems as alternatives to institutions will become increasingly salient. Perhaps predictably at this point there will be more of a thrust for family organization and consumer pressure for an array of extra-familial supportive and rehabilitative services for persons with mental illness. In addition to the family movement, we have also seen the growth of organizations of former mental patients, whom we call primary consumers. There are now a number of consumer-operated programs, encouraged by government initiatives and funding. In these rehabilitation models, formerly hospitalized persons, now in remission, serve as counselors, case managers, and role models for their still symptomatic peers. They offer understanding of the phenomenological experience of mental illness and the hope that a higher level of functioning can be attained.

The primary rehabilitation technology in the United States focuses on resocialization and skill-building, which are the best avenues to destigmatization and recovery of lost self-esteem. Undoubtedly these are the major needs of mentally ill persons throughout the world. In the main, the third world may offer the best soil for organic development of the rehabilitation modalities we consider most important: meaningful social relations, and meaningful work. But development of rehabilitation programs as a social priority requires initiatives from a variety of sources. We have learned that alliances of professionals, families, primary consumers, government planners, and interested citizens are the most effective mechanisms for bringing this about.

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NASMHPD POSITION PAPER ON CONSUMER CONTRIBUTIONS TO MENTAL HEALTH SERVICE DELIVERY SYSTEMS

The National Association of State Mental Health Program Directors (NASMHPD) recognizes that former mental patients/mental health consumers have a unique contribution to make to the improvement of the quality of mental health services in many arenas of the service delivery system. The significance of their unique contributions stems from expertise they have gained as recipients of mental health services, in addition to whatever formal education and credentials they may have.

Their contribution should be valued and sought in areas of program development, policy formation, program evaluation, quality assurance, system designs, education of mental health service providers, and the provision of direct services (as employees of the provider system). Therefore, expatients/consumers should be included in meaningful numbers in all of these activities. In order to maximize their potential contributions, their involvement should be supported in ways that promote dignity, respect, acceptance, integration, and choice. Support provided should include whatever financial, educational, or social assistance is required to enable their participation.

Additionally, client-operated self-help and mutual support services should be available in each locality as alternatives and adjuncts to existing mental health service delivery systems. State financial support should be provided to help ensure their viability and independence.

- Developed by an Ad Hoc Committee on Consumer/Expatient Involvement meeting in Cambridge, Massachusetts, February 23, 1989.
- Approved by Executive Committee of Human Resource Division of NASMHPD on June 13, 1989, for consideration by the full membership of the NASMHPD Human Resource Division for action at its annual meeting in October, 1989, in Omaha, Nebraska.
- Approved by NASMHPD Board 12/12/89, and by Membership on 12/13/89 at Winter Commissioners/Directors meeting.

Report of a World Health Organization (WHO) Meeting On Consumer Involvement in Mental Health Services

Mannheim, Federal Republic of Germany, 9-12 November 1988

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1. Introduction

A WHO Meeting on Consumer Involvement in Mental Health Services was held in Mannheim, Federal Republic of Germany from 9-12 November 1988. The meeting was convened within the framework of the WHO Medium-Term Mental Health Programme (Disability, Prevention and Rehabilitation) and was co-organized with the WHO Collaborating Centre in Mental Health, Central Institute for Mental Health, Mannheim, Federal Republic of Germany.

This was the third meeting convened within the framework of the WHO Initiative of Support to People Disabled by Chronic Mental Illness. The topic had been identified at previous meetings as one which urgently needed attention in order to increase recognition of the need for involving consumers in the design, implementation and evaluation of mental health services. The meeting aimed to identify ways in which consumers might become more actively involved in their own communities. Those participating in the meeting included consumers of mental health services, families of consumers of such services, professionals working with consumers and families, and government representatives interested in the financing aspects of consumer-initiated services. The list of participants is attached as Annex I.

The meeting was opened by Professor Doctor Heinz Hafner, Director of the Mannheim Collaborating Centre and by Dr John Orley, Senior Medical officer, Division of Mental Health, WHO. Professor Doctor Haffner and Dr Wout Hardeman were elected Co-Chairmen and Dr Ronald Manderscheid and Dr Nicholas Tarrier were elected as Co-Rapporteurs. The meeting was addressed by the Hon. Minister of Labour, Health, Family and Social Affairs for Baden-Wurttemberg, Mrs Barbara Schäfer.

2. Broad objectives of the meeting

2.1 To recognize the global needs of consumers and to address these in a publication which can serve as a guide for encouraging communities to involve consumers in mental health services;

2.2 To develop an outline for a multi-centre research and service demonstration network through which innovative services based heavily on consumer input can be designed and researched across cultures.

3. Specific objectives of the meeting

Participants were asked to focus on accomplishment of the following tasks:

3.1 Presentation of developments in each participants' local area on the topic of consumer and family involvement in community mental health services;

3.2 Determination of steps necessary for the development of greater input from consumers and families in community mental health service systems;

3.3 Identification of essential topics to be covered in a WHO publication on the importance of consumer involvement; and development of a draft of such a publication;

3.4 Identification of the core elements of a multi-site research and service network of consumer-based projects, and development of a concrete plan for implementing such a multi-site network.

4. Scope of the problem

Over the last few years there has been an increasing recognition internationally that individuals should take a more active role in decisions about health care practices which affect them. Autonomy is a key concept in health care ethics and the right to be consulted and involved in health care decisions —the right to give or refuse an "informed consent" is rapidly being recognized.

The WHO/UNICEF Declaration of Alma-Ata has affirmed this in Article 4 which states that "people have the right and duty to participate individually and collectively in the planning and implementation of their health care." (WHO 1978, p. 3). Although the Declaration of Alma-Ata did not specifically cover the needs of people with mental illnesses and mental health problems, later developments indicated that this Declaration should apply equally to such people.

This evolution has occurred because of the recognition that national and community self-reliance and social awareness are important factors in human development. Community participation should be encouraged by providing full information, encouraging literacy, and assuring that the necessary institutional barriers to participation of individuals, families and communities are removed so that responsibility for health and wellbeing can be assumed by them.

Although there have been numerous studies of participation by poor and disadvantaged groups in a wide variety of social programmes, citizen participation in mental health programmes has received little attention (McCord, 1982). The potential benefits of involving consumers and other community residents in the design and evaluation of the service system are numerous. These include benefits which result from the community members' knowledge of community needs, their investment in the services which are developed, and the political and economic support which they can provide to services to which they are committed (Zinober and Dinkel, 1981).

5. Publication on Consumer Involvement—Points to be included

5.1 Need of empowerment

The two words which most clearly sum up the current debate are "advocacy" and "empowerment" (see Rose and Black, 1985). Those who have suffered mental distress are often viewed differently from other citizens. Users of the mental health service system are often viewed as deviants and the labels "illness" or "madness" are stigmatizing. Services are often paternalistic and a medical model of care puts great weight on the views of the doctor. Empowerment requries control over service delivery and the planning, development and management of care. Empowerment can come in a variety of ways—simple respect for the individual reflected in the ability to give or refuse informed consent is one aspect; another is control over resources; and a third is the ability to speak with and on behalf of other service users openly and without fear of discrimination.

It is also important to realise that changing services is not the answer to solving the problem of services which are inappropriate. Changing attitudes of professionals and community members is crucial, and it must be recognized that consumers of mental heatlh services know more than anyone else about what is needed.

5.2 The consumer's right to representation

Patients admitted involuntarily to a psychiatric facility often lose their civil rights. They are generally not asked for their input about the kinds of treatment they will receive, including medication, and they often lose their rights to entitlement programmes such as pensions and social security benefits.

5.3 Access to medical records.

In many cases, patients do not have the right to see their own medical records. In some countries, the necessity of giving patients or their chosen representative access to their medical records has been recognized and is guaranteed by law. (Friends World Committee for Consultation, 1983).

5.4 Development and organization of families in mental health services.

The organization of families into advocacy groups for relatives with chronic mental illness is a relatively new development. There has been a school of thought which blamed families as the source of mental illness. This led families to challenge the mental health system and to join together to confront professionals with the need for more appropriate services (Hatfield, 1986). Recently it has been recognized that family members experience a high degree of stress from caring. This has been increased by deinstitutionalization and the move towards community treatment when relatives with chronic mental illness, discharged from hospitals, return to their home, with family members reassuming responsibility for their care (Johnson, 1986; Gersons, 1988).

One caveat is that with the advent of family organizations, service users (the patients themselves) have expressed concern that their wishes and needs will be subsumed under those of their more influential family members. In some countries relatives have powerful committal rights which can take away the person's rights and alienate the person with mental illness from the family (Gersons, 1988).

5.5 **Cultural differences in developing countries.**

In many developing countries the family is the most important unit of social survival. In most instances, whether located in rural or urban areas, individuals draw considerable support from their families. This is especially important in countries where social welfare benefits are nonexistent for persons with psychiatric disorders and where patients are completely dependent on the family for basic needs as well as for social and emotional support. Under these circumstances, it can be seen that family involvement in decisions which affect individuals with serious psychiatric disorders can be crucial. Furthermore, development of individual consumer advocacy groups comprised of patients would not only meet with disapproval and lack of success but would also leave patients without access to housing, food and shelter, and basic social contact and support (i.e. encouraging independence may be culturally and socially unacceptable).

A second issue is that in most developing countries the stigma attached to mental illlness is very great and families proceed with extreme caution when deciding who will know about the mental illness of a family member. Thus, expecting and/or encouraging families in developing countries to take on an advocacy role may be unreasonable (Nagaswami, 1988).

5.6 **Professionals' reluctance to involve families and consumers.**

The reluctance of professionals to involve families and consumers in the decision-making process and the reluctance of consumers and families to assert their views because of a fear of alienating professional staff were also pointed out.

6. **Multi-Site Project—Points to be included.**

As mentioned above, despite the growing consensus that consumers should be actively involved in decisions which will have a long-term effect on their lives, few programmes have been established based on systematic input from consumers, and even fewer attempts at systematic evaluation of these programmes have been carried out. Thus, a need exists not only to implement such programmes but to evaluate their usefulness and their effectiveness. Further, there is growing sentiment that it is possible to learn from the experience of communities across country borders. Therefore, even though there are many differences between countries, there are also many similiarities and, for this reason, it is felt that our knowledge could be expanded by comparing results of similar projects in different countries.

The following description was formulated:

> "The multi-site project is an attempt to innovate and improve the services which are delivered to those people with a risk of long-term dependence on the mental health service delivery system. In order to achieve such a goal, experimental projects will be started in several locations throughout the world under the coordination of the World Health Organization. These projects are likely to be radically different from already known services in at least two very significant ways. Firstly, these projects will be a joint effort of users, family-members and mental health workers. Together and with equal responsibility, they will develop, implement and evaluate the projects. Secondly, these projects will reflect the belief that the users of such services are best served by a system that takes them seriously and accepts their input as well as their needs and demands at face value."

Several topics were identified as being urgently in need of research. The following were included among this list:

(i) identification of the services which users see as being most important;

(ii) determination of the effectiveness of a range of services and the variance in effectiveness dependent upon characteristics of the user population;

(iii) determination of the cost-effectiveness of provision of services in the community;

(iv) determination of the most efficient means of returning individuals to the most productive position possible in the community;

(v) identification of the best means to help individuals attain maximum use of their portential capabilities;

(vi) determination of the most efficient range of services for the varying needs of persons with chronic mental illness bearing in mind the heterogeneity of the population and the changing needs of persons within the population;

(vii) identification of the best models of cooperation considering the various inputs of consumers themselves, families, staff and professional workers, citizen and other lay groups in the community;

(viii) identification of services that are generalizeable across cultures and country borders with special recognition of the need for identifying appropriate services for poor and developing countries.

7. Summary

Despite increasing involvement of consumers in other aspects of the health care delivery system, consumers of mental health services have rarely been involved in decisions about service planning, service implementation or evaluation of services provided. This lack of involvement, combined with the stigma attached to those with mental illnesses, has led to a situation where services have been increasingly under-utilized. As a result, greater numbers of persons with chronic mental illness have not received services which are beneficial to them, and families and community leaders are increasingly calling for more relevant services which will lead to better long-term outcomes and greater utilization of each person's capabilities.

Families have also organized into advocacy organizations and, most recently, in some countries have begun to ask for greater input into decisions which are made about the community mental health service delivery system. Additionally, all those concerned: consumers, families, professional mental-health workers, politicians, and insurers, have been seeking evaluation studies which will assess the relative benefits versus the costs of providing an array of services. Thus, there is increasing pressure from all sides to deliver effective, efficient, and cost-effective services which produce demonstrable outcomes. The aim of the meeting described in this Report has been to identify ways in which this effort can be encouraged and the concrete means by which WHO can facilitate research designed to answer some of these questions in an international area.

8. Recommendations

In order to carry forward the important work of WHO'S Initiative of Support to People Disabled by Chronic Mental Illness it was felt that several steps should be taken to ensure that the emphasis on consumer involvement in the design and evaluation of community mental health services is strongly encouraged. Thus, the following recommendations were made:

1. That WHO publish a document on involving consumers and families in community mental health services; further, this document should be written in persuasive and easy to understand language, which can be used by advocacy groups as well as governments to facilitate the involvement of consumers and families in community mental health services. It was particularly recommended that this document be widely circulated to call attention to the need for consumer and family involvement and to emphasise WHO's recognition of the importance of this topic.

2. That WHO develop a multi-site research and service demonstration network, which would be comprised of community mental health projects to be heavily influenced by input from consumers of mental services. This multi-site project should involve several sites which are globally representative and which include countries in both the developed and developing world. Further, this network of projects should be designed in a way that research can be carried out across sites, which will provide answers to some of the pressing questions identified about the best way to involve families and consumers in community mental health services. Further, this research should be designed to identify what is the best mix of services for the varying needs of this heterogeneous population, so that each individual is enabled to maximise his or her capability and live as productively as possible in the community.

3. That WHO establish a mechanism for synthesizing and disseminating up-to-date information about innovative community programmes and research. This dissemination should be aimed at the largest possible international community in order to disseminate the important findings as widely and as quickly as possible.

4. That WHO identify the skills necessary for training of staff at all levels to work with those with chronic mental illness and their families in community settings. Identification of these skills and the mechanisms for training staff should be widely disseminated to all countries.

5. That WHO identify the most cost-effective means of community mental health and rehabilitation services which will maximize the possibility for productive community living.

6. That WHO assist governments to ensure that legislation is enabling rather than restrictive. Further, WHO should emphasize that local and national legislation, as well as administrative policy, should encourage input from consumers and families via advisory boards and other oversight committees with policy-making power.

7. That WHO continue its efforts in line with the programme outlined in its Initiative of Support to People Disabled by Mental Illness. WHO should continue to focus attention on the need for consumer and family input into community mental health services and should continue to stress consumer input as a central theme running through this Initiative.

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Psychosocial Rehabilitation in the Developing World: Progress and Problems

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Introduction

The developing world is not a homogenous or uniform set of countries with standards of living or health care that are identical. There are developing countries with per capita incomes of less than US $200 per year and other so-called newly industrialised countries (NICs) with per capita incomes exceeding US $4,000. There are also enormous differences in provision of amenities and services to people in the developing countries particularly in health care. In most developing countries, both the richer and poorer, the health care systems however tend to be more urban and hospital-based and emphasize curative medicine or the life-saving arts and sciences. There is a steep drop in availability of medical care services once a person leaves the urban and developed cities. Psychiatric care in most developing countries often takes a backseat in the priorities of health care plans. The emphasis is on saving lives, not improving the quality of life—especially for people with mental illness.

While meagre resources and high mortality rates persist in developing countries, psychiatry it appears will remain in the doldrums of medical care. If psychiatry is a low priority in health of the developing countries, surely psychiatric and psychosocial efforts at rehabilitation must be the lowest priority in psychiatry. This then is the dilemma. There is no evidence that mental illness in developed countries is in any way less common than in developed countries and yet the resources available for the care of people with mental illness is very limited by the realities of manpower and budgetary constraints.

The developing countries for the most part have also been slow in changing the age old practices of institutional psychiatry where custodial rather than curative practices were and indeed are still seen as the priority. Despite this seemingly bleak and gloomy picture, some developing countries have made significant advances in innovating, adapting and spreading the process of psychosocial rehabilitation of their mentally ill. It would be useful to consider some of these experiences. As examples, the ASEAN group of countries in South-East Asia represent the NICs as well as truly under-developed regions and their experience in psychosocial rehabilitation may be a good example of the progress that can be made in psychosocial rehabilitation.

The ASEAN Region—A Brief Profile

The Asean region consisting of Brunei, Indonesia, Malaysia, Philippines, Thailand and Singapore lie in South-East Asia. The name ASEAN stands for the Association of South-East Asian Nations—an economic and political grouping of diverse and yet related nations. In area, the region covers about 1.2 million square miles and includes over 20,000 islands and parts of the mainland of Asia. In population, it has over 275 million people of many ethnic, cultural, religious and language groups. Economically, the region produces most of the world's tin, rubber, palm-oil, pepper and hardwoods as well as significant proportions of copra, rice, petroleum and natural gas for export. It is a rapidly developing region and until the recent oil and natural resource related slump had healthy growth rates. The medical care systems vary widely and although for the most part, no health insurance system exists, governments provide virtually free medical and health care to most areas of the country. Singapore is a modern but small city state with a high standard of living. Brunei Darussalam on the other hand has only 200,000 people but is probably the richest country in the world. Indonesia, Philippines and Thailand are all developing countries while Malaysia falls in between the two groups as a rapidly developing country.

Psychiatry in Asean countries is still fairly young in its development with only about six hundred and fifty (650) psychiatrists for the 275 million people or approximately one psychiatrist for every half million people (AFPMH, 1981). However, of these, practically eighty per cent (80%) work in the regions' big cities of Jakarta, Singapore, Kuala Lumpur, Bangkok and Manila. Thus, the rural or outlying areas of the Asean region are poorly served by psychiatrists and supportive services. The problems in Asean countries, however, are by no means unique and indeed there are many developing countries in other parts of the world where the situation is more acute.

Deinstitutionalisation

Most developing countries in ASEAN and other parts of the world have a legacy of institutional care of the mentally ill. In the past, the care was custodial but with the advent of modern medications and treatment modalities, there have been moves towards active treatment among institutionalized patients. The psychiatric institution is found by many developing countries to be a manpower and cost-cutting means of coping with mentally ill in large numbers. The acute shortage of trained professionals and funds however has a serious effect on the standards of psychiatric care and in fact adds to the problem.

In recent years, moves have been made to separate the practice of psychiatry from its institutional image. In Malaysia for instance in 1958, the first general hospital psychiatric unit was started in Penang (Tan, 1970). This is a short-stay acute treatment unit and is run by one psychiatrist and psychiatric nursing and ancilliary staff. The unit has about one-hundred patients who stay for less than a month on an average. Such units are today available in ten other places in the country while the four large mental hospitals of 350 to 2,500 beds are slowly reducing their intake of patients and discharging where possible their long-stay patients into the community. The move is at two levels—to deinstitutionalise the large, anonymous and often poorly kept institutions and make them more habitable, treatment-oriented, and where possible, turn them into shorter-stay hospitals. There should also be smaller short-stay units in general hospitals. A third level is the starting of rehabilitation facilities, partial hospitalisation and sheltered workshops as well as mental health movements aimed at psychosocial rehabilitation as well as prevention of mental illness at primary, secondary and tertiary levels.

In Singapore, an active mental health association has been doing valuable work in after-care of the discharged mentally ill patients. In Indonesia, there is a section of psychiatric rehabilitation in the directorate of mental health to look into the after-care of the discharged mentally ill patients. Attempts have been made in Thailand, Indonesia, Philippines and Singapore to move psychiatry to outlying clinics and smaller hospital units and to reduce hospital beds in the larger hospitals. In some cases, there have been success stories. In others, the practicalities of finance, manpower and organization make such forward looking moves difficult.

Occupational Rehabilitation Programs for People who are Mentally Ill

The history of psychosocial rehabilitation in the developing countries is at once ancient and new. So-called mental patients have been employed in work in the hospital's own kitchens, laundries and gardens for many years but the aim has been partly if not largely, to fill in the manpower needs and thus reduce running costs. It was only in the past thirty years or so, that work with the aim of truly rehabilitating the individual was embarked upon. The rehabilitation through work was the first of these measures instituted. The work involved was usually simple and often agricultural such as vegetable or fruit-gardening and sometimes, the more mundane jobs of cleaning, knitting or basket-weaving. Gradually, the move included simple industrial sub-contracts. These are still limited by high unemployment rates, availability of such industrial work and the location of the hospital. In Thailand, a mental hospital has six-hundred hectares of rice-fields which form an important source of psychosocial rehabilitation for the recovering person who is mentally ill. In Bali—where even in paradise, there is mental illness—at the Bangli mental hospital, coconut fibres are converted for mattress fillings and wire chain link fences are made for sale. In the Philippines and Malaysia, 'farm-wards' are an important phase of psychosocial rehabilitation for the long-stay mental patient. Vegetables and fruits are grown both for the hospital and for sale. This also provides a source of training for the patient about to be discharged.

In Indonesia, a brand of kretek cigarettes very popular there called 'REMEN' (for Rehabilitation Mental) is actually made by the psychiatric patients. In Kuala Lumpur, psychiatric patients run food services selling snacks, drinks and meals as part of their rehabilitation training. Since 1975, a wide range of light industrial work is being done in Malaysia on a contract basis by psychiatric patients in Malaysia. These include making of coconut-husk and leaf-brooms, plastic contract assembly work and in the past seven years, servicing of airline inflight audio headsets on a regular basis. Similar sheltered workshops in Singapore carry out a wide range of light industrial assembly work. There is a plan for an electronics microchip production and assembly plant for psychosocial rehabilitation in Malaysia. Some long-stay patients in Singapore's Woodbridge Hospital are retrained to do domestic work and have obtained jobs on discharge. In the sheltered workshops, there are opportunities for training as well as earning an allowance. In Kuala Lumpur, about thirty per cent (30%) of those trained in sheltered workshops actually obtain work in open employment and another 25-30% in some form of sheltered employment with friends or relatives or continue in the sheltered workshop. Another thirty per cent (30%) usually do not benefit and drop out.

Psychological and Social Rehabilitation

Although work is an important aspect of psychiatric rehabilitation, social and psychological rehabilitation are important too. This has necessitated the starting of day programs that are activity, discussion and group-orientated. These are still limited to only some parts of the developing countries. The western training of the psychiatrists, the traditional shyness of people in South-East Asia perhaps contribute to their relatively slow growth. Malaysia started its first 'Day Centre'—a partial hospitalization program with group therapy, social activity, psychodrama, art therapy and occupational therapy in 1969. Today, there are twelve such programs throughout the country. Similar programs are also available in small numbers in Bangkok and Singapore but largely not available elsewhere. The Day Centre movement with emphasis on group, psychological and social rehabilitation is still nascent and remains under-developed for lack of available expertise and funds. However, as more trainee psychiatrists learn this form of treatment in the training program, more such centres will hopefully be set up.

Mental Health Associations

One of the healthy and refreshing aspects of the developments in psychosocial rehabilitation in the developing countries is the recent growth of mental health associations. Formed from among lay and professional persons and psychiatric patients, they play an important role in the creation of awareness of mental illness in the population. They also help in early detection, psychosocial rehabilitation and to an extent prevention. Mental health associations in Thailand, Philippines, Indonesia, Singapore and Malaysia are at various stages of development. In Malaysia, there are eight such associations helping with the running of day centres, community programs and campaigns. Apart from these, there are related organizations that serve special problem areas e.g. telephone counselling services, shelters for battered women and child care centres that also do preventive work with abused children.

Psychosocial Rehabilitation of Drug Dependence and Alcoholism

The Asean nations are in the midst of one of the most dangerous routes of the illegal opiate trade. Heroin is easily available and heroin dependence is a major problem in Thailand, Malaysia and Singapore and becoming problems in Indonesia and Philippines. Despite efforts in the developed and developing countries, drug dependence especially to heroin remains a very difficult problem to treat. All Asean countries have very strict laws on drugs and for trafficking in drugs, the death sentence is often passed.

Thus far, thirty-nine traffickers have been hanged in Malaysia alone after being found guilty of trafficking in drugs. The unfortunate victims however are given treatment in a string of private and government-run centres and rehabilitated.

The main method of rehabilitation for drug dependence is by psychosocial means. The drug dependent person is given counselling, group therapy, occupational training and aftercare in the drug rehabilitation centres. The psychiatrists act as consultants in the early phase during detoxification and regularly visit these centres for treatment of psychiatric problems.

Alcoholism rates vary in the Asean region. The populations of Brunei, Indonesia and Malaysia are largely Muslims and hence alcoholism is a rare phenomenon among them. However, alcohol-related problems are fairly common in the non-Muslim countries and population—although its occurrence is believed to be less common than in many more affluent countries. In efforts to prevent its spread and promote treatment in Malaysia, there has been formed a privately-run association against alcoholism. The association (P.A.A.M.) is affiliated to two treatment centres that have regular A.A. type treatment groups and family therapy. There are moves to form more such centres throughout the country.

Prevention and Psychosocial Aspect

Psychosocial rehabilitation to be ideal must have a component of prevention in it. In the Asean countries, despite their many weaknesses, there exists some strength that prevents problems and prevents mental illnesses from worsening. This is true in many other developing countries as well. This strength is the strength of the families, family structure and the family support systems often breaking down or under pressure in many other countries. The discharge of the psychiatric patient does not immediately involve halfway housing, social security or social worker in most cases. The family is usually willing to take the patient home, care for him and bring him back if needed in most cases. This is a big asset as few resources are available to make up for support systems not available.

There is of course a need to minimise effects on the family due to economic and social pressures that can in the long-run erode these already present support systems.

Prevention of emotional problems should also be promoted through premarital, marital and occupational counselling as well as other detection and counselling systems in schools or colleges. These however are just beginning to be available. Large populations of vulnerable people still do not have access to these preventive and early detection services.

International Co-operation on Psychosocial Rehabilitation

There is no doubt psychiatry and psychosocial rehabilitation is a neglected art and science in many developing countries. Priorities for other health fields and economic problems contribute to make these the reality. But even with relatively meagre resources, a lot can be done for people with mental illness who need psychosocial rehabilitation in developing countries. Money is only one of the needs—there is perhaps a greater need for training and exchanges of views among countries to come up with new ideas and expertise. These can be done in many ways.

(1) There is a need for developing countries to exchange experiences in psychosocial rehabilitation. In the Asean region, an ASEAN Federation for Psychiatry and Mental Health (AFPMH) was formed about five years ago to bring psychiatrists from member countries for regular exchange of views on psychiatric topics. Visits by psychiatrists from the less developed to more developed among developing countries can be often useful.

(2) There is an urgent need for world organisations like WAPR and WHO and other international agencies to devote more attention to the plight of psychosocial rehabilitation problems in developing countries. The unfortunate 'revolving door' phenomenon of repeated relapses of mental illnesses and high chronicity and under-productivity are perpetual

problems of institutional psychiatry in developing countries. These vicious cycles need to be broken with some help from the world organisation.

(3) There is an urgent need for the developed countries to share their expertise with the developing countries that need them. This can be done by provision of short fellowships and attachments to leading psychosocial rehabilitation centres in the developed world for promising and energetic psychiatrists and allied professionals from the developing world to try and learn some of the techniques and systems for adaptation in their own countries.

(4) There is a need for a regular exchange of information among the developed and developing countries through a newsletter so that developments in the field can be shared. The developing countries can also contribute their experiences in overcoming challenging problems in their own countries with others who are facing similar problems.

Conclusion

The development of psychosocial rehabilitation for people with mental illness in developing countries is like a long journey. Most developing countries are just taking the first steps on this challenging journey and being beset by numerous doubts and problems. It is easy for overworked and exhausted, not to mention dejected psychiatrists with so many priorities in their lives and work to ignore or neglect psychosocial rehabilitation. They do so at not only their own peril but at the risk of turning many persons who can be helped into persons who will be a burden on their families and the developing countries. In developing countries, there are shortages of everything; money, food, clothing, education and of course trained manpower, and it is easy to give up, even before starting on that journey.

There is an urgent need for professionals from both the developed and developing world to put their shoulders to the wheel, find renewed strength and commitment to make psychosocial rehabilitation a living and vibrant reality for the untold millions of persons who are mentally ill.

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John Beard and Armin Loeb Award Nominations

Due November 15, 1990

The John Beard Award will be presented at the IAPSRS Conference in 1991 to the individual who has made the most outstanding contributions to the field of psychosocial rehabilitation in the preceding year or years. The contributions must have led to decisive and lasting advances in the field.

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An Example of a Community Based Mental Health/Home-Care Programme: Haidian District in the Suburbs of Beijing, China

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Xi Tingming, Tian Yunhua

Introduction

According to the Chinese cultural traditions, members in a family seem to have closer relation to each other than people in the West. They usually accept it as their duty to help one another economically as well as in other respects. In most cases, they tend to think it is their responsibility to take care of those members who are mentally ill in home, rather than to send them to a "psychiatry hospital." So, in China, most people with emotional difficulties usually remain at home and are looked after by other members of the family. Therefore, home care of persons with psychiatric disabilities may be more acceptable in Chinese cultural setting than in the West.

People who suffer from mental illnesses are in special need of sympathy, understanding and concern from those around them during the course of treatment. They need support not only from medical workers, but also from their family members, friends and the community they live in. If they are deprived the opportunity to take part in the activities of the collective and instead live in an isolated way, the result of the medical treatment would not be as effective as expected. In order to keep them from regressing, community based mental health care is absolutely necessary.

In China, there are already a number of primary health care centers in the villages. There was a hospital for each commune and there were "barefoot doctors" in each production brigade. These made it much easier for us to develop mental health care there and provide "sick-bed" in the home of villagers.

In June 1974 a health care network was begun to be established for psychiatric disorders in 11 communes in Haidian District which had a total population of nearly 190,000. Procedures were begun, such as the training of "barefoot doctors" and the medical personnel from commune hospitals and the identification of the people with severe psychiatric problems in the District. While giving the patients various kinds of treatment, the primary health workers paid visits to the patient's family from time to time under the supervision of staff from the psychiatry department. If the patients' condition improved, we would encourage them to join in more social activities. They either did some household work or took part in some collective farm labour. With this they could keep improving, and the result was quite satisfactory. More than 200 patients with schizophrenia received drug treatment in combination with this kind of home care. In the successive 5-6 years, good remission and marked improvement had been achieved in 60% of the patients with schizophrenia. Before getting this kind of community home care, only 2.9% (10/206) had kept up full-time farm work in the collective. But in 1979 this percentage rose to 47.1%. The number of patients who were unable to do any household work or take part in collective labour was reduced from 82% to 5.8%. This can never be expected in hospital treatment.

Setting Up a Community Mental Health Care Net in Haidian District

General Information: Haidian lies in the northwestern suburbs of Beijing, covering nearly 433 square kilometers of land. The population has remained stable. The birth rate was 16.96%; the death rate was 7.78%. Natural growth of the population averaged 9.18% a year. Density of population in this district varied from 278.4 person per kilometer to 550.2 person per kilometer. According to the 1979 census study, 27.4% of the population was aged 0-14; 62.7% aged 15–59, and 9.9% was over 60. Male to female ratio was 1:1.2. Structure of families had been changing in recent years. There were found a few extended families. When children grew up and got married, they formed their own families, but they usually continued to live in the same courtyards so that they could still help each other. Each family consisted of four members on an average. The income of most of the peasants in this district had risen to close to that of people who worked in the city. The communes that ran factories or other enterprises and those whose chief income was from growing vegetables and fruit trees were naturally richer than the communes in distant or mountainous areas where nothing grows but grain. The average income for each member of the richer communes was double that of the poorer ones. In four communes located close to the city, the commune members enjoyed free medical care and even funeral expenses were provided by the collectives. Children could attend the kindergarten free of charge, and enjoyed ten years of school at public expense. In the outer suburbs the communes were not very rich, the peasants could only enjoy partial free medical service and other kinds of public welfare. Junior high schools had been popularized since 1949 and senior high schools since 1975. Literacy was very high. Only a few illiterate persons could be found in the age group over 60.

Procedures for Establishing a Mental Health Care Net

Psychiatric training of medical personnel: Attention was given to the training of one to two medical personnel from each commune hospital for a period of 4-6 months and one to two "barefoot" doctors from each production brigade (village) for one week. A total of 240 "barefoot doctors" and 14 hospital's medical personnel were trained. The average ratio between the number of "barefoot doctor" trained and the population of village was 1:750. The ratio between hospital's medical workers trained and commune population was 1:13, 000.

Field survey: A list of persons with suspected mental illness in each production brigade was provided chiefly by the "barefoot doctor" in charge. Key information was collected from the head of brigades, the police, and the psychiatric department of the district polyclinic. A psychiatric interview of each patient with suspected mental illness was carried out by an experienced psychiatrist. The average time spent in examining each patient was about one hour, including a case history taken from the patient's relatives. Diseases investigated included different kinds of psychoses, mental retardation and epilepsy.

Systematic drug treatment for those indicated: Psychiatrists from our institute together with the "barefoot" doctors in charge and medical workers from the commune hospitals periodically called on the patients under treatment.

The investigation and organization of mental health care services throughout the district were completed by February 1977. A total of 1,333 patients with severe mental illness were identified and 787 home beds were settled by the end of February 1977.

In the agricultural Haidian district the prevalence rate of schizophrenia was 1.82%, reactive psychosis 0.26%, manic depressive psychosis 0.07%, other psychoses (involutional, ateriosclerolic, senile, presenile, psychosis due to intoxication or infectious disease) 0.27%, epilepsy and mental disorders epileptic in origin 2.1%, and oligophrenia (severe and moderate degree) 2.57%. No alcoholism or drug addiction was found then.

Clinical Features of Schizophrenia and the Therapeutic Effect of Community Home Care

In the 300 cases of emotional disorder among 156,200 people in the 11 communes investigated, the clinical data are shown as follows:

Prevalence rate: The prevalence rate was 1.9%. For males it was 1.2% (87/74,5000) while for females it was 2.6% (213/81,700), with a sex ratio of 0.46:1. The prevalence in both sexes rose from the 25-29 age group, peaking in the 40-49 age group. Male prevalence was comparatively higher than that of female under the age of 30-34 but female prevalence went up after age 35, then rose straight up until the age of 40-49. This was 2.5-3.2 times higher than male prevalence (February 1977).

The prevalence rate of 10 communes ranged from 1.0% to 3.2%. The highest prevalence of schizophrenia was found in Yuyuantan Commune, with the highest density of population, which borders on the city. Difference in prevalences did not seem to have a significant relation to the average income or to the geographic position of the communes in our district.

Clinical features: The general clinical features of schizophrenia in this district indicated a high degree of chronicity and a long duration of course, with 71.1% as chronic and sub-acute and 28.9% as acute. Disease course extending five years was 68.5% and that extending beyond ten years was 39.3%; 19% (61/300) obviously deteriorated. Among them 46.8% had a chronic course (symptoms persisted), 16.8% a progressive course, 26.9% a remittent course and 9.4% only one episode.

Mental Status During the Field Survey: In course of the field survey 77.7% (233/300) had obvious psychiatric symptoms; 7% (21/300) was in partial remission; 15.3% (46/300) in good remission. Clinical types included paranoid 54.3%; chronic 19.7%; hebrephrenic 11%; simple 2%; peudoneurotic 0.7%; catatonic 0.3% and others 12%. As a rule, these chronic patients were looked after by one of the family members and lived in a separate room. They were isolated from the social life for a long time and did not participate in any collective labour. The survey also showed that among the patients 62.3% had received treatment, 7.5% had been treated only for a short time and 30.1% had never received any prior treatment. The reasons varied significantly: some of them were skeptical about the treatment, saying that mental illness could never be cured, while others believed that emotional illness was due to the fault or lack of morality of their ancestors. Still others were reluctant to be treated in any way simply for economic reasons.

Follow-up Study after the Setting up of the Community-Home Care Service in the District

All patients received an average course of drug treatment of 2-3 months in combination with home care and were followed up as long as possible. The result of this kind of mental health care was promising: good remission being achieved in 35.9% (74/206) and marked improvement in 32% (66/206) in 1979. The working capacity of the patients in the family or in the community was obviously improved. Out of the 206, 134 were found fully recovered. Before the treatment, only 10 out of the 206 were doing normal farm or household work. From January to February 1982 a team of two senior psychiatrists and one resident was sent from our institute to these communes for an intensive investigation. All the schizophrenic or possible schizophrenic patients who had had contact with the medical workers of the primary health care in that district or other mental health services in this city were interviewed by the team. The recovery of the patients in their social and family functioning in these communes in 1981 was about the same as in 1979 for the whole district. The patients who took part in normal farm work or household work in the year of 1981, made up 44.19% and 11.63% respectively. Only ten of the patients could not work: five because of chronic deterioration, one had a new episode and the other four had exacerbation of psychotic symptoms.

Albeit, China is undergoing significant socio-economic development in most recent years, the community-based mental health care program continues to function. For instance, according to the statistic data, by the end of 1986, the total schizophrenic population in Haidian District had grown to 367 against that 206 in 1979. Out of the 367, 34.1% (N=132) was in remission, 25.6% (N=99) was markedly improved, 25.8% (N=100) was improved, while only 14.5% (N=56) remained unimproved. This distribution is very close to that in 1979.

The work of developing mental health home-care in the primary health level not only benefits the patients and lightens the burden on the state, it also promotes the people's socialist ethics all over the country. In short, what we have done over these years in the rural areas is based on our understanding of the principles of mental health, of the social environment of the patient, the importance of normal social activities and family support to one's psyche and his own state of mind. This may explain why we have obtained some fairly good results in our research program. And another undoubted factor is the superiority of the socialist system. For without the support of the Health Bureau of Haidian District and the close cooperation of the patients' families and the whole community, we could not have been able to achieve such results cited above.

A Brief Synopsis

Out of 217 cases of schizophrenia defined in the national epidemiological survey on psychiatric disorders in 12 areas in China, 176 cases with a course over 5 years, 121 cases over 10 years, and 102 cases of paranoid schizophrenia with a course over 5 years as three groups were analysed with multiple stepwise regression in the computer to screen out those factors which might play key roles in the prognosis of schizophrenia. 18 variables selected in this analysis were sex, marital status, family history, life event, physical cause, time of relapse, drug treatment and family care, etc. Results uncovered that the most influential factors for this prognosis, in order of importance, were first family care, then times of relapse and drug treatment. The relationship among these three main factors and the implication of these results in the development of tertiary prevention in community were also discussed in detail in this report.

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N.B. This study was possible as a result of policies instituted during the cultural revolution. Since 1987 the program has changed considerably as Haidian district has become more urbanized.

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Nigeria: Report on the Care, Treatment and Rehabilitation of People with Mental Illness

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There are nine psychiatric hospitals of varying sizes in a country of about 90 million. Sizes vary not only in terms of ground space but also in terms of patient population. Initially during the colonial period (Nigeria was a British Colony untill 1960) the three psychiatric hospitals, were located in the Southern part of the country. These housed a large number of patients. With the creation of other psychiatric services in the country, and particularly with active efforts to depopulate the hospitals, the in-patient population in the large psychiatric hospitals has been considerably reduced. It has to be noted that when we talk of large in-patient population, we are talking in terms of hundreds and not thousands. Also initially, the hospitals were more custodial in function than actively therapeutic, and they were indeed called asylums and the psychiatrists were called alienists in keeping with the tradition of the British and the rest of the world at the time.

Active therapeutic activities were initiated in the mid 1950s and the use of "asylum" and "alienist" also started to be changed. Now psychiatric services are concentrated in the southern part of the country. There are still as many as five states (mostly in the north) of the 21 political states in the country without any modern psychiatric service.

The question may be asked as to what happens to persons with severe mental illness in places where there are no modern psychiatric services. Some of these were and are still kept in prisons and indeed some prisons were gazetted by the Colonial government as asylums. Some people are in the care of traditional healers. In this regard it has to be mentioned that a large number of the general population still believe that persons with severe mental illness lie more within the competence of traditional healers than modern psychiatry. Syncretic religious cults claiming to have healing power, and ability to cast out devils in mentally ill patients are attracting these patients. They are called syncretic because they combine aspects of Christianity and traditional religion in their practice.

Treatment by Traditional and Religious Healing Methods

The care and treatment of persons with mental illness by the traditional healers generally involves the active participation of relatives of the mentally ill. In fact the relatives have to live with their ill member in the compound of the traditional healers to provide creature needs of the patient and also to participate in the healing rituals. The treatment consists of administration of herbs and performance of rituals with recitation of incantations. Rauwalfia Serpentina has been identified as one of principal components of the traditional healers concoction. This has known anti-psychotic properties. The patients movements are restricted within the compound by some physical contraptions to prevent them from running away and doing any harm. They are given more freedom of movement as their mental state improves and they are involved in household chores and other village community activities. Some traditional healers who are also farmers engage their patients in farming sometimes in lieu of professional fees.

Even though it is not identified as such, rehabilitation is built into the system of care and treatment by traditional healers by the involvement of the patients in the various activities mentioned depending on their mental state. Some patients stay with traditional healers for years.

The care and treatment of persons with severe mental illness by syncretic religious cults have not been studied in depth. It is conceivable that the religious healers also apply physical restraints for the disturbed patients. They use mostly prayers and the annointment of holy water and holy oil. The patients also participate in the singing and dancing which are part of their rituals. Since these activities go on till very late in the night—sometimes all night—the patients do not sleep. The improvement of patients with depressive illness (if any) may be due to the enforced insomnia, which is known to have some therapeutic effect on some depressed patients.

Care, Treatment and Rehabilitation by Modern Psychiatry

Patients very seldom come in on their own. If they do, they are usually sent back to bring a relative. The reason for this is that patients are not treated in isolation from significant persons to them. In any case what a patient reports of him / herself cannot be relied on absolutely. A third person account is therefore considered very essential for assessment.

All kinds of subterfuge are used to get psychotic patients to come to the psychiatric hospital. In cases where the patient is resistive, destructive, or aggressive, physical measures are taken not only to subdue him / her but also to facilitate his transportation to the hospital. Ropes have been used to tie their hands behind their back, and the ankles together, fetters have also been used, as well as handcuffs, as well as wooden blocks with horseshoe-shaped metal to hold the ankle. The patient is brought with these contraptions, the most traumatic of which are the ropes which are often too tight and impede blood circulation causing swelling of the extremeties. The contorted position in which the patient is forced can be severely uncomfortable and agonizing.

These physical restraints are used more by rural communities without adequate modern health facilities. These patients in pain and severe discomfort on arrival in the hospital beg to be relieved of their suffering and promise to co-operate with the hospital staff. In most cases, especially if they have travelled long distances, they are so exhausted that they are subdued. The first question we usually ask the patient is why he has been so physically restrained. The usual answer is that he does not know, or if he is paranoid, that they want to kill him. Then we ask those who have brought him why they have had to restrain him physically. They then recount his aggressive, destructive behaviour. The patient is then asked his reaction to the relatives' report. This is usually denial or the patient may be abusive.

If his relatives have reasons to bring him to the hospital by this method we have to look critically into the situation and we can only do this with the patient's cooperation with us. Anxious to be relieved of his discomfort, the patient is willing to cooperate. He is then untied. In the meantime, a full history is taken from his relatives, and if the patient himself is not too disturbed his own version of his history is also taken. In this situation, it is not considered advisable to try to treat the patient as an outpatient, as he is not likely to cooperate with his relatives. He is admitted into hospital and the relatives, especially if they have come from a long distance are expected to stay around. The Village around the hospital is available for such a situation.

For those who live nearby it is possible to treat such highly disturbed patients on an ambulatory basis, by giving high doses of anti-psychotic drugs and giving daily appointments to assess the situation.

In the big cities where medical services and law enforcement agents are available, different strategies are used to take very disturbed patients for treatment in modern psychiatric facilities. Such patients are some times forcibly sedated at home and then taken to a psychiatric facility where previous arrangement has been made for admission. The issue of the right of the individual does not arise as his right is considered to be contingent on the right of his family who are at the receiving end of the patient's embarrassing, aggressive and destructive behaviour.

To avoid the possibility of psychiatry being used to put away an individual for nonclinical reasons, the patient on recovering from sedation is assessed with the background information already given by his family. It is almost unheard of for the hospital or the family to be taken to court by such patients for illegal detention or violation of their human rights. This is particularly striking when it is appreciated that such patients in the cities are sophisticated and are familiar with the concept of human rights and legal process. In fact it is when they are having a relapse of their psychotic illness that they threaten to take legal action against family members and psychiatrists for their earlier involuntary admission to hospital.

Another strategy which is often used is to invoke the law. Members of the family swear an affidavit in court stating their observation of the psychotic behaviour of the ill member before a magistrate who then issues a court order for the admission and observation of the ill member for a given period which can be extended. It has to be noted that even though the law books talk only about observation, in practice treatment is initiated as soon as it is ascertained that the patient is psychotic. This practice has never been challenged in court. This is the formal legalistic way of getting a disturbed patient to treatment. Even though admission by this process is involuntary, the involuntary nature of admission ends with the period stated by the court, but treatment continues on voluntary basis. It is only when the patient continues to be very disturbed at the expiration of stated period, that the hospital seeks to extend the period.

A less formal way of invoking the law is to have a patient arrested for an offense which he has committed. This arrest is often prearranged by the family who then appear to be on the patient's side; by giving the information to the police about the patient's possible mental illness. Instead of the patient being processed through the criminal justice machinery, he is committed for treatment in a psychiatric hospital. Since it is his criminal behaviour that has brought the weight of the law to bear on him, he cannot blame his parents. On the other hand, he pleads for the parents' effort to get him out. The parents advise him to cooperate with the hospitals authorities, as they are the only ones who can effectively inform the court that he is able to be discharged.

This account of how patients are brought to the modern psychiatric facilities will not be complete without mentioning two other situations. One concerns forensic psychiatric cases referred to psychiatric service for observation and report or for detention. In this regard most psychiatrists have always insisted that the accused or convicted person referred to them must be accompanied by relatives and request detailed a account of the criminal behaviour of the individual concerned and also back ground history.

The rationale behind this request is that those referred to psychiatrists are those who have committed very serious offenses, particularly homicide. One cannot rely entirely on the account given by the concerned person, nor can one rely exclusively on the result of psychiatric assessment without information from other relevant sources. Furthermore, the objective of psychiatric intervention is treatment with the expectation that the treatment will be successful. If this expectation is achieved, the psychiatrist will have accomplished his objective and it is the responsibility of the criminal justice system to decide on the disposal of the case. The rational disposal of the case is discharge to the custody and care of relatives. If relatives have not been involved in the treatment programme from the beginning, it will be difficult to have them accept responsibility at discharge, even if they can be traced at this late stage.

The other situation is when vagrants who seem to be psychotic are collected from the streets for humanitarian, political, cosmetic or research reasons and psychiatry is invoked in their management. From time to time destitute people are collected from the streets of large cities with the stated objective of rehabilitation. These destitute people often include people with physical disabilities and some with psychosocial disabilities and occasionally those without any apparent disability. Experience has indicated that psychiatrists should only accept involvement on the condition that the concerned authorities should make available all that is needed by the psychiatrists to do their work effectively—drugs, equipment, trained personnel. If the primary concern of the authorities is cosmetic—to rid the streets of what they consider eye sores—than they should leave psychiatry out; but if they are equally concerned about the vagrants who seem to be psychotic as individuals who need psychiatric help, then psychiatry can usually be involved.

The occasion has been used to warn the authorities to avoid the mistakes of technologically developed countries which built large asylums which later became a bane to psychiatry and psychosocial rehabilitation.

The Initial Psychiatric Interview

The Psychiatric Interview should be a group activity because as many significant members of the patient's family, friends, co-workers as are present are invited to participate. The patient is first asked what his problem is, having been reassured that we are there to give him our specialist attention. In some cases, the patients give only somatic complaints like insomnia, and loss of weight. The accompanying relatives and friends are then asked about the reason they have come with the patient and their observation. The degree of his acceptance of the relatives report is a measure of his insight. If he accepts there is something wrong with him, it is easy to treat him, and in this case he may even be considered for treatment on an out-patient basis if he is likely to cooperate with his relatives. Even when he fails to accept that there is something wrong with him, we focus on his problem of insomnia and loss of weight for which we can help him. The level of his functioning in various areas are also explored and almost invariably some areas of dysfunction like giving up his job and isolating himself are identified. These are also used to persuade him to see that he needs help. On the basis of this, we persuade him to come in for admission. With this approach involuntary admission is considerably reduced.

When the patient lacks insight and becomes aggressive, interrupting the interview, he may be asked to step out of the room to allow the relatives to talk more freely without interruption. The technique we use is to ask the patient to accept admission to hospital for observation to confirm or refute the report of his relative. Since we do not live with him we are not in a position to assess the veracity of the report of his relatives, and he will be helping the situation if he were to accept admission to enable us make our own observation. Some times this does not work, and the patient has to be forcibly sedated to be admitted. It is interesting to note that most of the patients who say that there is nothing wrong with them accept medication and other treatment modalities without any objection once they are admitted to hospital.

During the initial interview of the patients and relatives, the family dynamics are some times exposed. One critical parent and the other indulgent, the double bind phenomenon, the expressed emotions, the manipulating and coping method of the patient, sibling rivalry, the passive father or mother, the overbearing father or mother—are all exposed and notes are made of this not only to guide the decision on where the patient is going to be treated—outpatient or inpatient—but also the degree of family therapy that will be needed.

In addition to the above, the initial interview affords the opportunity of establishing rapport with the patients. It is not expected that all detailed information will be collected in the first interview, but the foundation will be laid, and the atmosphere of confidence created which will facilitate future interaction. Further more, the initial interview may indicate the seriousness and complexity of the case.

The decision on whether to admit a patient into hospital or treat the patient on out patient (ambulatory) basis is based on clinical and sociological considerations: Clinical in terms of level of insight, level of cooperation, suicide risk, level of aggression, how long the patient has been ill; sociological in terms of availability of relatives to look after the patient at home, distance to the hospital, tolerance or intolerance of relatives, how much of a physical and/or emotional strain it has been for the relatives. They may need to be given a respite, but are they looking for a place to dump their ill member?

A plan of treatment and management is discussed with the relatives and also with the patients if he/she is amenable. The role of the hospital, of the relatives and of the patient are defined. It is emphasised that the relatives have a vital part to play in the treatment process which does not end with hospitalization, and this includes regular visits.

Treatment Modality

Treatment is based on the findings of both physical and mental state examination; and also relevant laboratory investigations. Minor physical ailments are treated by psychiatrists.

Psychiatric treatment includes formal entities like psychopharmacology and group psychotherapy, occupational therapy, electroconvulsive treatment as well as the informal ones such as hospital melieu, superficial psychotherapy, family therapy geared towards drawing relatives' attention to unhealthy interactions; psychotherapy with the patient is geared towards identifying patients' abnormal experiences like delusions and hallucinations with the aim of letting the patient appreciate that these experiences are symptoms of illness. It is futile attempting this when the patient is not amenable or at the height of his illness. It is only when drug therapy has had its desired effect that psychotherapy can be effectively started.

The patient is helped to recall the genesis of his illness, the circumstances surrounding the beginning and early symptoms. In this exercise his relatives may be invited to add their own observation, and their own reaction. In doing this, both patient and relatives learn about mental illness, how to prevent relapses and how to nip it in the bud before the patient looses touch with reality.

In situations where the patient does not recall his abnormal behaviour or continues to deny it, a "confrontation interview" is arranged in which the relatives are invited to relate their observations to the patient in the presence of hospital staff-nurses and psychiatrists. The effect of this is some times dramatic. It is as if the veil is lifted and the patient suddenly appreciates his abnormal and sometimes offensive behaviour. He may become remorseful and apologetic to his relatives. It is at this stage that discharge of the patient can be considered and planned.

There are cases however in which every effort to open the insight of the patient to the same degree fails. This is when we have to be satisfied with the positive change in behaviour and the patient can still be considered for discharge.

Individual psychotherapy is complemented by group psychotherapy which can take different forms. It may be for selected patients; it may be for a mixed group of patients. The hospital staff who act as catalyst may be nurses, psychologists or psychiatrists. The patients are informed that this is an essential part of their treatment. They are requested to relate to what brought them to the hospital and their experiences. They learn from each other and they come to realize that their psychotic experiences are not peculiar to them. They give each other advice. It has been observed that it also has a socialising effect especially with patients who are withdrawn.

The occupational therapy includes a wide range of activities, depending on the facilities available and the imagination and skill of the therapists. In addition to updating the patient's skills, new skills are taught. The psychopathology and symptoms of the patients are taken into account in planning activities for them. They play games and dancing sessions are also arranged for them. The nurses accompanying patients to the occupational therapy department participate in the social activities. By so doing they get to know the patients better. Where possible some of the individual activities like knitting, are continued back on the ward.

When relatives visit their ill members, the interaction between them and the patients are watched by the nurses, and when necessary the nurses may intervene, especially when relatives do not show much understanding of the nature of the illness and tend to be critical and blame the patients, or when they are over indulgent.

There are regular weekly ward rounds in which all the members of the treatment team sit with the patients in turn and they review the progress and treatment of the patients. If any relative happens to be around, he or she is invited at the appropriate time to participate. Reports are given from the different perspectives of the team members. The patients are asked to react to these reports. Their action is usually indicative of their progress. Further treatment and management are decided at these ward rounds.

The patients compliance with the treatment programme is very high, especially where unsophisticated and not too westernised patients are concerned. Our patients do not seem to be interested in the nature of their medication or how it works. There have been situations when relatives who have heard of ECT or seen the positive changes in other patients, have requested the treatment for their ill member not knowing the indications for it. It is the responsibility of the staff to explain the indications to them, and to assure them that appropriate treatment is being given.

Discharge Procedure

Discharge of patients from hospital is considered on various interrelated parameters. It is not enough for the patients psychosis to subside and his behaviour return to normal. It is essential that he has considerable insight into the nature of his illness and its manifestation. It is also necessary to ensure that the relatives are satisfied with his/her improvement. They are invited to express their views, anxiety, misgivings, anticipated problems and expectation. Their reaction to the patient is explored, and they are advised about management at home. The need for maintenance medication is explained and they are advised to monitor this.

The plan for the patient in terms of his occupation, education and day to day living is discussed with patient and relatives, so that a rational decision is made before the patient is discharged. The continued participation of relatives in the treatment programme from admission facilitates the discharge procedure and a number of issues will have been addressed before the consideration for discharge.

When all these arrangements have been made, the patient is discharged to the care of his relatives with an appointment for follow-up attendance in the out-patient clinic.

In some cases, especially those in which the relatives still harbour some misgivings about the patient's readiness to return home, or the patients have been ill for a long time, trial discharge or parole for increasing time periods is practised. During the trial, emerging problems are resolved and the adaptation of the patient to living at home becomes a gradual process.

Follow-Up

The philosophy behind the follow-up exercise is that we all have our breaking points which are constitutionally determined and there is very little we can do about it. What we can modify is the environmental factor which has triggered off the psychotic process. In some cases, this environmental factor can be identified. Some are inevitable as part of the process of living. In that case the patient may need to take his maintenance medication for a long time until his circumstances change. For instance getting an educational or professional qualification, getting married may help to fortify the patient from further breakdown.

An appropriate and reasonable parallel to psychosis is malaria (table 1). A person who lives in an endemic area for malaria will continue to have malaria fever periodically until he / she develops at best a partial immunity. If he is to avoid a recurrent malaria fever, he has either to quit the endemic area which is equivalent to his changing his constitution in the case of psychosis, and this is not possible, or taking his prophylactic antimalaria drug regularly which is equivalent to taking his maintenance medication regularly. This is the rationale for maintenance medication. Even then, it is not an absolute. A person on his prophylactic antimalaria drug may still develop malaria fever if he has a massive dose of infection, but the fever will be attenuated. Similarly a person susceptible to psychotic illness may still breakdown in spite of his maintenance medication, but the illness will be attenuated and can be arrested before it blows up. Follow-up is therefore a primary preventive measure.

Relatives are expected to accompany the patients on their follow up appointments. In addition to the patient's self report, relatives are asked to relate their observation of and feeling about the patients. With this we can get some knowledge of the dynamics in the home and suggest changes or modification where necessary. It is only when the patients are well stabilized that the need for the relatives' attendance may not be considered necessary.

At the initial stage follow-up appointments are frequent, and they get progressively prolonged as the patient stabilizes, and the maintenance medication is reduced to the bearest minimum or even discontinued.

In situations where the trigger factor is identified and it is necessary for growth and development like academic or professional examinations for instance, the patient's maintenance medication is discontinued early, but he / she is asked to report when he is preparing for another examination. He is carefully supported with psychotherapy and if need be with medication to tide him / her through the stressful period.

Concluding Remarks

The pattern which has been described is the standard practice but the extent to which it is followed is determined by many factors which include the type of training the psychiatrist has had, his experience, the availability, training, experience and perspective of other members of the psychiatric team, and material resources. Where there is absense or shortage of specialized psychiatric team members, as there are in many cases, those available will need to be flexible in their roles. In such cases, we cannot afford compartmentalized roles. The perceived need and gap will have to be met and covered by those available.

We have found that nurses can function as therapists, psychiatric social workers and even occupational therapists when the need arises. In fact, in Nigeria experienced senior nurses have started and run psychiatric facilities before trained psychiatrists came on the scene, in a few situations, and they have done very well indeed. It is also to their credit that when psychiatrists became available, they were able to work with the psychiatrists without manifesting any reaction of displacement from their pioneering and leadership status. It also must be said that this acceptance of their changed status was facilitated by the maturity of and appreciation by the psychiatrists, who regarded the nurses as true partners in the care of people with mental illness.

Table 1
Comparison of Malaria Fever and Psychosis

	Malaria	Psychosis
Predisposing Factor:	Living in endemic area of malaria	Constitutional genetic
Immediate Precipitating Factor:	Infection by Malaria Parasites	Stressful environmental factor which may be cumulative.
Treatment:	Antimalaria drugs	Eclectic including psycho pharmacology 'psychotherapy' occupational therapy etc.
Prevention of Relapse:	(a) Relocating to non endemic area if possible (b) Taking prophylactic antimalaria medication. Manipulation of environment by sleeping in screened rooms or under mosquito nets.	(a) Changing constitution and genetics—which is not possible (b) Taking maintenance medication and manipulation of environment when possible; especially Expressed emotion (EE) element
Relapse:	(a) Massive dose of Malaria Parasites when on prophylactic medication (b) Attenuated fever which can be nipped in bud	(a) Overwhelming stress when on maintenance medication (b) Attenuated psychosis which can be nipped in the bud.

A Model For the Care of People with Psychosocial Disabilities in Sri Lanka

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This paper reviews the problems and care of people with psychosocial disability in general and discusses the mental health program in Sri Lanka in the context of social, cultural and economic factors in the society. A model for the care of people who have psychosocial disabilities is proposed and a project based on this model is described. A preliminary evaluation and recommendation for an improved program is attempted.

In spite of modern treatment methods, high relapse rates and prolonged social disabilities continue to affect the long term outcome of schizophrenia. Approximately 30% to 50% of people diagnosed with schizophrenia develop relapses and an equal proportion develop social disabilities. There is evidence to suggest that the outcome of schizophrenia in other developing countries is somewhat better; however, even in these countries about 25-30% do not fare well in the long term.

During the last three decades many western societies have been responsive to the needs of people with mental illness and particularly those who are chronically disabled and have developed favourable social attitudes which led to a series of changes in the care of this group of people. Large numbers of long term hospitalized patients have been discharged to the community. Psychiatry has been integrated to the general hospitals increasingly and many welfare measures have been introduced to support people with disabilities in the community. Legislation has been liberalized to help persons who have mental illness.

During the same period many advances have been made in the area of clinical psychiatry. Prophylactic medications have been successfully used in the prevention of schizophrenic relapses. Social and psychological factors precipitating relapses have been identified and new techniques of psychotherapy have been introduced to aftercare programs. Family counselling and social therapy have been practiced with varying success. Newer techniques such as behaviour modification, assertiveness training and social skill development have helped a large number of rehabilitation programs. Clients with long-term disability who are in the community without residential facilities have been provided with hostels and group homes.

In order to meet these expanding services, an increasing amount of resources, both man-power and finance have been diverted to programs related to psychosocial disability. Development of the subspecialty of rehabilitation psychiatry, training of non-psychiatric and non-medical health professionals, introduction of community mental health workers and a variety of other facilities no doubt have helped people with severe mental illness.

The development of programs, however, have not been uniform due to social political, economic and cultural factors in different societies. Among the different models, the community mental health centre concept in the U.S. and the district based community care model in the U.K., are well known. Similarly, models have been developed regionally; for example in Bangalore in India and in South Verona in Italy. It is in this context that I have been exploring the possibility of developing an appropriate model of care persons who have severe mental illness in Sri Lanka.

Before the discussion of the details of the proposed model, let me present a description of the mental health program in Sri Lanka.

The Existing Mental Health Program

The state mental health program in Sri Lanka was established by the British colonial government when legislation was introduced to establish an asylum for the insane in 1838. Since then, except for the opening up of follow up clinics during the World War II and establishment of a few general hospital units in the sixties, all the mental health activities have been revolving around the mental hospital. There have not been any significant changes in many areas of mental health legislation. No attempts have been made to deinstitutionalise the long stay patients or to develop community based facilities, such as aftercare and rehabilitation programs. Mental health care has not been integrated with general health care in a substantial way.

At present there are about 3500 inpatients and about 3000 of them are in the four mental hospitals situated outside the capital, Colombo. Nearly 2000 of them are long stay patients. About 500 short term patients are scattered among 6-8 general and teaching hospitals in the major cities. There has not been a significant change in the number of total beds during the last few decades although the bed occupancy rate has dramatically increased. Inpatient units are often overcrowded and the patients have to travel long distances to reach a psychiatric facility, bypassing a number of general health facilities. The number of long stay patients remains static in the mental hospitals. However, there had been a rapid turnover of patients both with a first episode as well as relapses of psychiatric illnesses. Increasing numbers of patients have been in contact with the psychiatric service during the last few years. There are out-patient clinics (both follow up and assessment) attached to most psychiatric inpatient facilities. The University Psychiatric Unit, General Hospital Colombo has increased its admissions by 300% during the last 15 years. The average inpatient hospital stay is about two weeks. Similarly the mental hospital admissions too have increased dramatically due to admission of patients with relapses. A very large percentage of people diagnosed with schizophrenia are treated as outpatients with neuroleptics. The admissions are voluntary, except for forensic and other crime related mental disorders. Very few health professionals other than psychiatrists work with psychiatric patients. Most psychiatric facilities are in urban areas and more than 50% of the psychiatrists work in the city of Colombo.

Although psychotic illnesses form the major work load of the psychiatrist, increasing numbers of patients with non psychotic illnesses continue to come in contact with the mental health service. According to present evidence, the vast majority of people with schizophrenia do come in contact with psychiatric facilities sometime during their illness, at least once.

Apart from the allopathic practitioners, there are a number of other types of healers in Sri Lanka. Ayurveda, faith and religious healing methods and healing methods related to the occult are common. They out number the allopathic healers and many people with mental illness consult these traditional healers at sometime during their illness. In long standing disorders these healers perform more a supportive role than a major one. Many patients while resorting to the allopathic system for the cure of the symptoms, tend to consult other healers to remove the alleged causes of the disorders. The commonly incriminated causes are supernatural influences, environmental stress, disturbances of humours or damage to brain. The social, cultural and educational background of non-allopathic healers is closer to ordinary people than in the case of allopathic practitioners. Further, they more often work informally in the community than do the allopathic healers.

Discontinuation of drug therapy is often a major factor in relapses. It is not uncommon for patients to stop medication immediately after suppression of the symptoms. Apart from the difficulties involved in travelling to the follow up clinic, many patients discontinue drugs due to a variety of reasons. Misconceptions about mental illness and its treatment is one of the chief reasons responsible for default.

The development of mild social disabilities do not appear to worry the relatives very much. However, serious disabilities associated with schizophrenia bring about enormous distress to the patient as well as to the family. Proposed marriages are not uncommon in patients suffering from mild schizophrenic disabilities and often this is seen by the parents as a solution to the behaviour problems of the patients. The spouse is often not aware of the illness and the development of a relapse after marriage some times leads to marital and other problems. Many families look after the disabled member at home either because of the sociocultural reasons or lack of appropriate institutions for they suffer a great deal in doing so.

Social stigma and misconceptions regarding mental disorders often prevent the families from seeking assistance from the community or discussing the issues involved. Only the most severely affected individuals are admitted to the long stay hospitals, and about 80% of the present long stay patients cannot be discharged as many of their relatives are not able to care for them. Further, the government has not provided any welfare facilities to maintain them in the community.

The well developed primary health care structure—family health workers, health education officers, public health nurses, public health inspectors and medical officers—are often not involved in the care of people with mental illness. In the absence of a separate mental health division in the health administration, there is no overall authority responsible for the planning of the services in the country. At present, additional financial resources for mental health is unlikely. To a great extent the training the mental health professionals are given is biomedically oriented and hospital based. The community health professionals have had very little experience in the practical aspects of care of people with chronic disability. The institutional mental health professionals strictly work in isolation and have very little contact with patients or their relations once they leave the hospital, except at the follow up clinic for very brief periods.

A major obstacle to the development of a good mental health program is the lack of finances. Although accurate statistics are not available, it is estimated that about 2.5% of the health budget is spent on mental health. About 8% of the national budget is allocated to health. Programs associated with large scale investments or dismantling of existing organizations are unlikely to be implemented especially in developing countries. Such programs have not been successful either. The lack of trained professionals is another limiting factor. There is a lack of organized voice on behalf of the mentally ill, at all levels of the society. A high literacy rate, easy accessibility to health care facilities in the country, good communication and transport facilities make it easy for the health education and training and care programs to be conducted. Compared with many other developing countries, Sri Lanka enjoys a relatively high standard of health care according to standard indices, perhaps due to improved social welfare programs and effective primary health care measures. Eighty percent of the economy is agricultural and in the non-urban areas the pressure for employment is less.

The extended family system is still a common feature and often relatives live close to each other in rural areas. As in the other eastern cultures, individuals tend to be dependent to a great extent on the family. Parents invest a large amount of resources in children with great expectations. In the same way children are expected to support the parents whenever necessary. The responsibility of looking after a disabled individual is often the responsibility of the family.

Some of the resources required for better mental health programs are: manpower, technical and even financial that are available in the extended family system, formal community health structure, informal health system and voluntary organizations based on the community have not been fully explored. The existing educational and training programs, health care professionals and the social support systems could be made use of in the proposed model. It may be possible to utilize some of these resources in a more efficient manner. The proposed model is based on the assumption that these community based resources if efficiently harnessed could contribute a great deal to the development of better mental health care. On this basis, the activities should be carried out in the community itself, with its participation. If such a program is developed for proper aftercare and rehabilitation of chronically disabled persons in the community, some of the distress associated with illness and disabilities and their consequences may be alleviated. The care of people with mental illness in the community also has several other advantages which have been documented.

Proposed Model

The proposed model is based on the following:—

a) A large number of individuals with chronic disability at present live in the community with their families.
b) The patient as well as the families suffer a great deal as a result of the disabilities.
c) Development of appropriate aftercare and rehabilitation programs may improve the quality of life of people with mental illness and their families.
d) These programs could be developed with the utilization of the existing resources.
e) In doing so, large scale investments or dismantling of existing facilities are avoided.

In order to achieve these aims, it is essential to develop techniques, train personnel and educate the community. It is necessary to develop a centre based in the community from which all these activities could be initiated. The activities of the centre should co-ordinate and facilitate the existing human service systems to work towards betterment of people with psychosocial disabilities. The professionals in the institutions and the people in the community should have a free access to it and in fact the relationship should be encouraged. This is an important aspect in the implementation experience has shown that the organizations tend to polarise either towards community or institutional settings, with very little communication between the two. The centre is expected to develop suitable programs for assessment, preventive therapy, rehabilitation, education, and training of the community. The centre should have facilities for crisis admissions, follow up, counselling, education and living skill training. The running of the centre should be by a small staff assisted by personnel from the institutions as well as from the community by volunteers. The local community and institutional facilities should be freely available to the centre and vice versa.

A project along these lines was initiated in 1983 in Colombo. The initial objective of the project was to serve people with severe disabilities, but increasing demand necessitated the expansion of the activities towards the entire spectrum of mental disabilities. All the resources had to be found for the project outside the government sector and the project was carried out as a pilot program. The first phase of the project consisted of the development of a community mental health centre. As this was a new concept in Sri Lanka initially a day care centre was established for people with severe disability who were attending a psychiatric follow up clinic.

This day care centre was started in a two-room apartment in a residential area in Colombo with a trained occupational therapist as the only employee with the objective of offering aftercare facilities. He was assisted by a handful of dedicated volunteers who had no training in the management of mental illness. The daily program consisted of living skill training, recreation, occupational therapy and group discussions. Within the next few months the centre became very popular and an increasing number of patients were referred by psychiatrists and others.

The activities of the centre were directed by a group of mental health professionals led by the author, and the overall policy planning was done by an elected group of people from the membership of the National Council for Mental Health. Funds were raised from the public. The increased work load necessitated the centre to be shifted to bigger accommodations within one year and finally to the present site, a spacious building in pleasant surroundings in Colombo. In view of the variety of programs undertaken it was renamed a community mental health centre. Many community educational programs were organized making use of mass media. Several training programs were organized for the volunteers as well as for other health care professionals in and around Colombo. A psychiatrist from the University Psychiatric Unit, General Hospital Colombo conducted a daily clinic in the centre. The facilities of the hospital unit were made available to patients attending the centre when necessary.

At present the centre has a permanent administrator and three other staff members, 40 volunteers and two psychiatrists helping to run the centre. For the psychosocially disabled group the aim was to develop an aftercare and a rehabilitation program. At any given time a minimum of two staff members are available at the centre.

The trainees (the centre does not use the word "patient") find their own way to the centre. The trainees from distant places sometimes live with their relatives in Colombo in order to attend the centre even for a short time. The regular family counselling, discussions and educational programs are conducted to help the families of trainees to manage them better at home. Attempts to develop vocational training programs were not successful, for a variety of reasons. An average of 10 trainees are referred to the centre monthly and there is an average of 30 attending daily. The trainees spend the day in the centre from

9 a.m. to 4 p.m. The attendance as well as the program is made flexible in order to fit the requirements of trainees. The CMHC was accepted by the neighbourhood with sympathy and understanding. Many volunteers and other health professionals who were frightened of people with mental illness largely due to ignorance gradually became close supporters of the centre. About 50% of the running expenses of the centre are met by voluntary donations of trainees. So far all resources have been directed towards the development of the CMHC, and no attempts have been made to link up with the existing community networks. The next stage is to expand the activities of the CMHC while community linkages are being developed.

A total of 328 trainees have been referred to the centre during the last 3 years and almost all of them were suffering from chronic schizophrenic disabilities. Detailed records of 311 are available. 197 trainees were males. 101 trainees came from within the city and 127 were from suburbs. The remainder were from distant places. Two thirds of the trainees were under 30 years and most of them had been ill for periods over five years. About 15% of the patients referred to the centre did not feel that they would benefit and decided to drop out initially. About 25% of the trainees attended regularly and the rest were irregular in attendance.

Although a formal evaluation of the project has not been done, it is possible to draw certain conclusions from the experiences gained in conducting the programs for the last three years. It was not always easy to convince family members and/or the trainee of the necessity to attend the centre even for a short time, except perhaps in the case of people with prolonged illness. Some patients as well as their relations did not want to be associated with the centre as they felt that the latter was meant for the severely disabled mentally ill. Many requested drugs to cure their disabilities. Several trainees and their families did not want to be associated with an institution which carried a social stigma. Living skills, educational and recreational activities were popular. Lack of expertise, finances and difficulty in selling the finished products as well as difficulty in securing jobs for trained personnel discouraged the development of vocational training programs.

The problem of travelling and the associated cost prevented many from attending the centre regularly, especially the female trainees who had to be accompanied by another person. Some failed to realise the relevance of the activities in the centre to their day to day life. Many relatives did not feel the necessity of attending the self help group at the centre. Lack of transport prevented many volunteers from visiting the homes of trainees who defaulted. The lack of a crisis intervention facility, residential accommodations, a follow up clinic and transport facilities diverted a large number of patients away from the community mental health centre. Due to a lack of a community outreach program many drop-outs could not be traced. The lack of a core group of people with training in community mental health interfered greatly with the efficient functioning of the centre. The selection of staff with appropriate training and experience was always a problem. Lack of professionals and difficulty in grasping the objectives of the program among the staff members also had the same effects.

The training programs were enthusiastically attended by the volunteers and health care professionals. In the absence of any financial assistance from the government, the necessary funds had to be raised from the public. The necessary amounts were not realised and some planned activities had to be abandoned because of a lack of money.

Lessons Learned

Many lessons have been learned from the pilot project. The impression is that in spite of a series of inadequacies and difficulties, there is a vast potential in the proposed model. In order to be effective, many modifications are necessary in the implementation of the program. Establishment of a formal structure in the CMHC and the methods of communication with institutions, formal community health and other welfare organizations and families is essential. It is desirable to have at least a few well trained mental health professionals at the centre who could be supported by personnel from the community-based agencies. A close link between the centre and the local psychiatric institutions is indispensable.

The education and training program has to be carefully designed with clear cut objectives for the health workers—formal as well as informal—in the locality is essential. It is essential for the centre to develop innovative ways of dealing with varying demands of mental illness.

The centre should not make an attempt to provide services for all persons with mental illness in the area. On the contrary, it should coordinate and facilitate the mobilization of resources in the existing community networks in an informal manner. The centre should run more as a model with dynamism. The experience has shown that the establishment of formal day centres, vocational training programs and residential accommodations on their own are not priorities. The CMHC should have the following capabilities:

a) Assessment
b) Follow up
c) Crisis admissions
d) Living skill training
e) Education
f) Training

Regular funding should be guaranteed. The planning of the activities should be the responsibility of a group of professionals from health, social services and other community organizations. A program incorporating these recommendations is to be implemented in the near future.

Integration of Psychosocial Rehabilitation in National Health Care Programmes

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Psychosocial rehabilitation of persons with chronic mental disability has begun to assume importance in the Third World only very recently. This is not really surprising as developing countries face an uphill struggle with other more pressing problems and mental health, understandably, occupies low priority status in the planning concerns of national policy makers. This paper outlines the existing situation and discusses possible strategies to improve the lot of people with severe mental illness. While most of the material presented here is drawn from the experience in India, it is believed that the issues discussed have the possibility of being generalised to other developing countries as well in view of the similarities in the needs of the people with severe mental illness and the resources available to them, in most Afro-Asian cultures.

India is a vast multi-ethnic, agrarian, secular, developing democracy with a population of approximately 800 million persons, most of whom live in rural areas. Health care planners are preoccupied with provisions of basic amenities like sanitation and with programmes directed at the control of communicable diseases. An overview of the National Mental Health Programme and the state of people with severe mental illness in India would be an appropriate prelude to a discussion of issues pertaining to psychosocial rehabilitation.

The National Mental Health Programme (NMHP)

Approximately 1500 psychiatrists and an equal number of clinical psychologists and psychiatric social workers (a grand total of about 3000 mental health professionals) form the country's manpower resource. Together, they deal with the needs of about 20 million service seekers. With postgraduate teaching centres producing only about 150 psychiatrists and fewer trained psychologists and social workers, a reversal of this unequal equation appears a bleak prospect. One mental health professional per 250,000 population and one mental hospital bed per 32,500 population are appalling equations by any standards.

Bearing in mind the above limitations, senior mental health professionals and national policy planners encouraged by the findings of a WHO collaborative study on strategies of extending Mental Health Care (Sartorius, 1983), by the Alma Ata Declaration (WHO, 1978), and fuelled by the recommendations of a WHO study group on Mental health care in developing countries (WHO, 1984), came together in a series of seminars, workshops and small group discussions to formulate the National Mental Health Programme for India (NMHPI, 1987).

The NMHP has the philosophy of decentralisation and integration of mental health in the Primary Care Infrastructure. Realising that mental health professionals alone could not cope with the increased demand or services, the NMHP adopted a policy of training primary care personnel in the first level management of mental health problems. The multipurpose workers (grassroot primary care staff) are trained to detect mental disorders—psychoses, epilepsies, mental retardation, alcoholism and drug abuse—and to motivate the sufferers for treatment. Physicians at the Primary Health Centres are trained in the principles of management of these conditions.

The NMHP seeks to ensure availability of basic mental health care for all, encourages application of mental health knowledge in general care and promotes community participation in the development of mental health services. The recommended strategies include diffusion of skills and transfer of technology to the periphery, establishing a referral system, balancing territorial distribution of resources, integrating basic mental health care into the general health service and linking mental health with community development.

The NMHP is a welcome first step taken by the Government of India to offer affordable mental health care to the most underprivileged members of Indian society. Unfortunately, the funding allocated for the NMHP under the seventh five year plan of the government is far from satisfactory. A sum of ten million Rupees (less than US $1,000,000) has been allotted for the entire five year period, thereby limiting the scope of the programme's implementation. Despite these shortcomings, it is an encouraging sign that the government has been sensitised enough to initiate specific programmes for mental health, however modest the beginnings may be.

People with Severe Mental Illness in India

There are no available estimates of the number of people with chronic mental illness in India. Epidemiological studies carried out in various parts of India have demonstrated a point prevalence rate of 2.6 to 17.2 per 1000 population with very little rural-urban differentiation. It is reasonable to speculate that a substantial number of these cases would fall under the classification of chronic mental illness. This presumption is further strengthened by reports from an epidemiological study of 100,000 persons living in the slums of Madras city (Rajkumar, 1988). This study, although finding a low prevalence rate for Functional Psychosis (3.6/1000) has demonstrated that a large percentage of the population have been ill for more than two years and experience considerable social disabilities. Few studies of incidence rates of mental illness have been carried out in India, and an assessment of the magnitude of the problem can be made only on the basis of the figures. Suffice it to say that approximately 5 per 1000 (4,000,000 Indians) would be severely mentally ill and in urgent need of services.

Persons with severe mental illness have very few organised services for their rehabilitation and have to be satisfied with the services offered by mental hospitals and general hospital psychiatric units—the former being custodial in nature and the latter usually pharmacotherapeutic. Most mental hospitals in India offer one form or other of occupational therapy for their residents and the bigger institutions run well organised vocational rehabilitation programmes for day boarders as well. The National Institute of Mental Health & Neurosciences, Bangalore, the Central Institute of Psychiatry, Ranchi, the Institute of Mental Health, Madras, and a handful of other teaching centres have well organised industrial and occupational therapy programmes catering to about 100–150 service seekers at a time alongside a psychosocial rehabilitation programme. Their main disadvantage lies in their geographical location—within the campus of the mental hospital—which makes the patient more dependent on the hospital's services and in the long term, hampers social reintegration.

Along with governmental services, a handful of voluntary agencies are also trying to grapple with the problems faced by people with severe mental illness. Most of these agencies are urban-based and poorly funded as a result of the antipathy to people who are mentally ill, and offer services ranging from job placement to crisis intervention.

The NMHP, while realising the importance of rehabilitation, makes only a mention of rehabilitation, and does not recommend any specific strategies for the purpose. The 'Rehabilitation sub-programme' section of the NMHP states that "rehabilitation of psychiatric patients will be greatly facilitated by maintenance medication of epileptics and psychotics at the Community level. The counselling regarding principles of rehabilitation would be provided by the medical officer at the Primary Health Centre wherever practical, rehabilitation centres would be developed at the district level as well as higher referral centres" (NMHP, 1982).

Maintenance medication is undoubtedly one of the components of rehabilitation, but can never be considered an end in itself. The Medical Officers at the Primary Health Centre are already overburdened and it would not be feasible to let them shoulder the responsibility of rehabilitating people with severe mental illness.

The reasons for the neglect of people with severe mental illness are manifold and complexly interwoven with the matrix of Indian society's internal conflicts. A few of the more tangible reasons are highlighted below:

> Possibly the most important contributory factor is the *absence of a suitable, cost-effective, easily replicable model of rehabilitation for people who are*

mentally ill in India. Western models cannot be transplanted in their entirety in view of the wide disparity in manpower and funding resources in India compared to the developed world. A redefinition of the goals and targets of rehabilitation is urgently required. A few centres have done some quality research work on the aftercare of persons with severe mental illness and in the areas of disability prevention. The time has now arrived to consolidate all the knowledge and experience in the country and formulate a feasible model for rehabilitation.

Social attitudes toward mental illness are notoriously negative and until some form of attitudinal change is brought about, people with severe mental illness will continue to languish.

Most rehabilitation research and services in recent times have been *hospital based.* This increases dependence on the hospital's services and creates an alternative social network which the rest of society does not want to be a part of. This worsens the sense of isolation and hampers social reintegration for people with severe mental illness.

Professional apathy is an extremely unfortunate phenomenon. In India, very few mental health professionals are motivated to work with people with severe mental illness on long term basis. Poor career prospects and imagine stagnation keeps the professional away.

It is not really surprising that *policy planners are apathetic to the needs of people with severe mental illness.* The policy planner requires data inputs from mental health professionals and a lack of professional interest or support ensures a state of ennui on the part of the programme planner.

Poor utilisation of health—general and mental—services is a very frequently occurring phenomenon for a variety of reasons—dissatisfaction with the services geographical inaccessibility, belief in traditional healers and illiteracy, are a few of the more important ones.

Obvious factors such as the lack and unequal distribution of pecuniary and manpower resources are also extremely contributory.

Psychosocial Rehabilitation Policy

It is evident from the foregoing that no clear psychosocial rehabilitation policy exists in India. The NMHP has not developed any guidelines for developing such a policy, nor has this issue been addressed by the Mental Health Act of 1987. People with severe mental illness are shunted between two Ministries—the Ministry of Health and the Ministry of Welfare—neither of whom accept responsibility for them. An urgent need for a cogent policy for rehabilitation can be identified, more so because the health care provider is going to, in the years to come, be faced with the problem of large numbers detected by the NMHP who were previously the community's responsibility. Offering a service where none existed automatically shifts the entire burden of the care of people with severe mental illness on to the shoulders of the care provider and also increases the community's expectations of the service unrealistically. It becomes imperative for the policy planner to gather more information about psychosocial rehabilitation. The blame for such a sorry situation cannot lie with the policy planner alone. Mental health professionals in India are largely apathetic to the needs of people with severe mental illness. In the absence of concrete data on psychosocial rehabilitation needs and methods it is reasonable to expect the policy planner to launch initiatives directed at people with severe mental illness.

The apathy of the policy planner and the mental health professional is but a reflection of the social stigma attached to people who are mentally ill. Rural communities continue to have a magico-religious explanatory model for mental illness and people with severe mental illness consequently do not receive the benefit of modern medical care. The high illiteracy rates and poor media exposure to the problems of people with severe mental illness does little to improve the situation. In urban India, people with severe mental illness are victims of social antipathy and neglect despite the better level of literacy. This stems not merely from lack of information about mental illnesses but a deep rooted fear of social ostracism of the families of persons with mental illnesses. The mental health professional engaged in rehabilitating people with severe mental illness has to handle not only the problems of poor manpower and limited resources, but also has to handle the frustrating social phenomenon of stigma and quite often the professional's best efforts come to naught when the person who is mentally ill is discharged from treatment/rehabilitation programmes.

Some critical issues for policy

In the West, rehabilitation is entirely in the hands of the mental health professional. This is possible only in situations where funding and manpower resources are proportionate to the needs of people with severe mental illness. In India, the mental health professional is not in a position to take on the entire responsibility of rehabilitating people with severe mental illness. Moreover, it is well established that rural communities have a well integrated social network, which the planner can take advantage of. It may be well worth considering the suggestion made here of permitting the community to shoulder the responsibility of rehabilitating its citizens who are mentally ill.

Mental illness has been reported in Ancient Indian medical literature as early as circa 600 BC (Namboodri, 1986) and extremely accurate description of psychoses can be found in the medical treatises of the period. Although explanatory models of psychotic disorders have changed over the years, it is fairly certain that the community has had to cope with the burden imposed by people with severe mental illness much before the onset of modern medicare. An effective style of coping with people with severe mental illness must have emerged over the generations which mental health professionals have to address their enquiries to. What is critical is that the community has coped and is still coping. How does it do so? An answer to such a question would be of immense importance to policy planners; it is entirely possible that with minimal inputs, the community could be encouraged to cope better and ensure a better quality of life for people with severe mental illness.

Traditionally the goals of rehabilitation are in the direction of encouraging the person with mental illness to lead an independent and productive life (Bennett, 1983) and most rehabilitation professionals seek to reduce the dependence of the individual on the health and welfare services (Anthony, 1977). Paradoxically, this independence and functional autonomy is emphasised after producing a state of dependence on the health care service, making the problem much more difficult to handle. Resettlement is considered the final goal of any rehabilitation team (Bennett, 1983). This would imply that the professional assists the client in locating housing, finding a job and managing to survive in a competitive environment in the case of less severely mentally ill persons, and offering permanent sheltered employment for the more severely disabled. This approach would not suit Indian conditions very well. Unemployment, poverty and inadequate housing are national problems, and have to be dealt with in the national development perspective. Offering such facilities for people with severe mental illness immediately accords them 'privileged status' and further alienates them from the communities they are trying to be a part of. The professional unwittingly, defeats his own purpose by taking such an approach to rehabilitation. The goals of rehabilitation in India should be more limited and pragmatic, focussed on strengthening the support of the community.

It is extemely important that the rehabilitation service should be offered at the level of community itself. Taking an individual from the community, training him/her in specific skills at a centre and attempting to bring him back into his community can be quite hazardous, as the community's expectations of both the individual and the service is high and the acceptance of the individual may be difficult.

It has also been our experience that mental health care and rehabilitation programmes cannot be offered in isolation from other health care and development services. An integrated programme in a defined catchment area becomes necessary. Good programmes should also be easily replicable, capable of being integrated in the existing infrastructure, utilise minimal professional inputs, not dislocate the individual from his/her natural environment, harness the valuable resource potential offered by the family, not alienate the client from his/her social environment by according him/her 'privileged status' and focus on augmenting the community's support system.

Psychosocial Rehabilitation Research

A recent review of rehabilitation research trends (Menon, 1985) emphasised the paucity of Indian research programmes in this field. Most research programmes have addressed themselves to vocational rehabilitation/occupational therapy and few programmes have been undertaken to evaluate the efficacy of psychosocial interventions. With the exception of a handful of research programmes (Nagaswami, 1985; Suman, 1980; Shaila Pal, 1985; Nagaswami, 1989) most centres undertake quality research in more 'glamorous' psychiatric frontiers. This, too, stems from the poor funding offered to rehabilitation related research by national funding agencies, who prioritise basic and clinical research. Medical research priorities are geared more towards the study of communicable diseases using a Public Health approach. Mental Health research and rehabilitation research are not as well funded. An urgent need exists for research programmes to be undertaken, if only to convince the policy planners that rehabilitation of people with severe mental illness is feasible.

Below are a few questions that researchers in developing countries may wish to address:

1. What are the perceived rehabilitation needs of persons with severe mental illness in rural communities?
2. How do rural communities cope with their mentally ill citizens? An understanding of this phenomenon is vital in planning and implementing services in rural areas.
3. What kind of intervention would be appropriate? Western models of rehabilitation cannot, for reasons described above, be transplanted in their entirety in Afro-Asian cultures. Interventions will have to be culture-specific and cost effective rehabilitation models with a wide coverage have to be developed and field tested.
4. Is the Primary Care infrastructure strong enough to cope with additional rehabilitation inputs? It is vital that the design of the rehabilitation model allow for integration in the existing infrastructure to ensure continuity of care. This question is of great importance to the policy maker.
5. Psychoeducation—How, where and to whom?
6. What is the role of the traditional healer? The traditional healer occupies a pivotal role in the community's social support system. Strategies of working with such healers and not against them need to be evolved.
7. How best can rehabilitation outcome be defined? It is being increasingly recognised that relapse rates and social adjustment are not quite enough in assessing the efficacy of social intervention strategies, more so if they are community intensive. A redefinition of outcome indices is an urgent need.
8. What is the most cost effective rehabilitation model in developing countries? It is speculated that developing countries need to move away from the client intensive approach that obtains in the developed world. Rehabilitation programmes in the third world require to be not only community based but also community intensive. The latter term refers to the community as the recepient of the thrust of the programme with people with mental illness being an indirect beneficiary.

Community Based Rehabilitation

The macro planning of rehabilitation programmes in developing countries is an extremely challenging proposition. Paucity of funding and manpower resources pose seemingly insurmountable hurdles and the policy planner has to excercise considerable imagination in optimising the use of all available non-material resources in providing care. The gap between mental health needs and resources is extremely wide in India and the policy maker's current preoccupation is to narrow this gap as much as possible without straining the nation's already overburdened exchequer.

It is now well recognised that the most feasible approach to rehabilitation in developing countries is to draw on the community's available resources. The World Health Organisation has recently demonstrated the feasibility of evolving Community Based Rehabilitation (CBR) programmes for people with physical handicaps. The Government of India has also demonstrated its concern for the physically handicapped by undertaking a series of CBR pilot programmes and appears to be committed to developing such programmes at a national level. CBR attempts to identify volunteer resource persons from within a given community and offer decentralised rehabilitative inputs channeled through these resource persons who are expected to implement simple rehabilitation strategies. It is entirely possible that CBR programmes can also offer a mental health component without overloading the system if simple training and rehabilitative measures could be devised, targetted at the social reintegration of persons disabled by severe mental illness. Such attempts have been reported from countries like the Philippines and it was felt that a similar pilot effort in India would yield valuable outputs as well.

Integrating Psychosocial Rehabilitation in National Mental Programme

Conducting sensitisation seminars and lobbying with policy makers to include a strong component of psychosocial rehabilitation within the framework of the NMHP did not produce the desired results mainly because of the absence of hard data on the necessity and efficacy of such programmes. It was considered appropriate to initiate a demonstration project, preferably with the support and involvement of national policy planners. Accordingly, a modestly funded project by the government of India has been initiated by the Schizophrenia Research Foundation (India), a non-governmental organisation, in a rural catchment area of 100,000 population. An outline of the project entitled "Integration of Psychosocial Rehabilitation in the National Mental Health Programme" is presented below.

The Scarf Experience

a. ***Objectives of the Programme***

With the above background in mind, SCARF decided to initiate an experimental pilot CBR programme with the following objectives:

1. to examine the feasibility and efficacy of initiating CBR programmes in a defined rual catchment area.
2. to elucidate the qualitative and quantitative data that would be required for such programmes.
3. to devise simple rehabilitation strategies that could be deployed by the untrained lay worker at the village itself.
4. to study the cost-effectiveness of such a programme.

b. ***Logistics***

The first hurdle to be overcome was the identification of a catchment area and examination of its infrastructure. The solution came easily from the Indian Red Cross Society (IRCS) who, for the past four years, has been operating a CBR programme for people who are physically disabled in a defined catchment area. It appeared that "piggy-backing" on the IRCS's program could be useful in not only working towards the program's objectives, but also in assessing the feasibility of integrating a mental health component in an existent CBR program for physical handicap. The IRCS's CBR program, identical to the one undertaken by the Government of India, lent further support in terms of ensuring long-term continuity of this pilot effort. Accordingly, after a period of liaison and negotiation with the IRCS, a protocol was drawn up to expand the scope of their programme with inputs from SCARF, to include persons disabled by mental disorders.

The IRCS operate in a defined rural catchment area about 60kms south of Madras city. Thiruporur Block in the district of Chingleput in the state of Tamilnadu covers an area of 141.81 sq. miles. 110,758 persons (55,893 males and 54,865 females) live in 102 villages and depend on agriculture and fishing as their primary source of income. Their health care needs are catered to by six doctors and about 70 Multi-purpose Health Workers (MPWs) working from one Primary Health Centre, three additional Health Centres, two rural dispensaries and six maternity centres, all run by the state government. In addition to this six medical clinics/hospitals are run by voluntary agencies and charitable institutions. A few private practitioners serve those who can afford their services. The 43,861 children in the Block receive their education from 66 schools scattered throughout the region.

c. ***The IRCs CBR Programme***

In 1984, the IRCS initiated their CBR programme in Thiruporur Block in a phased manner. Three permanent project staff (all non-professionals) liaised with village leaders and requested them to identify responsible young persons, preferably women from their villages who were educated (at least secondary school) and who would assist in the rehabilitation of the disabled. These women are called Rural Community Rehabilitation Workers (RCRWs) and offered a nominal stipend to cover their transportation costs. One RCRW was identified to serve a population of 1000 persons. The RCRWs were trained using the WHO CBR manual in detecting persons with orthopaedic, visual and auditory handicaps and mental retardation. They then conducted a door to door survey in their defined regions and have so far screened 80,000 persons in the Block. The remaining population is presently being screened for disabilities. So far 5,935 persons with physical handicap and mental retardation have been identified. The RCRWs arrange for the disabled persons to be examined by specialists in special clinics conducted by the IRCS at different sites in the block, and plan interventions. The existing interventions include provision of orthopaedic & hearing aids, spectacles and arranging for surgery as appropriate.

d. ***The SCARF-CBR Programme***

The SCARF-CBR Programme was conceived of as a pilot exercise in four phases:

Phase I: Training of a selected group of RCRWs in the principles of detecting mental illnesses.
Phase II: Setting up mental health camps to medically treat the detected cases.
Phase III: Integrating mental health in the existing health care infrastructure by training health care personnel in the detection and medical management of mental disorders.
Phase IV: Developing a methodology to offer simple rehabilitation approaches including vocational rehabilitation, social skills training and family psychoeducation at the level of the village itself by the RCRW.

The Project started in October 1988 and the first four phases have been completed.

Training

20 RCRWs catering to an approximate population of 20,000 persons have been trained in two batches. The participatory-training programme was offered by a Psychiatrist using audio-visual aids. The trainees were provided basic information to be able to detect five categories of mental disorders identified by the NMHP—psychoses, depression, epilepsy, mental retardation and alcohol/drug abuse. They were also trained in motivating persons with such disorders to accept medical treatment. They were given one month's time to do case finding and refer them to the proposed mental health camps. They were not required to undertake a door-to-door survey, but were to use their knowledge about their communities in detecting cases.

Mental health clinics and follow up

In the second phase, four centrally located villages were identified and mental health camps were organised in all of them on a weekly basis. The cases detected by the RCRWs were evaluated by a visiting psychiatrist and medication was initiated. At each camp the RCRWs were further sensitised about handling day to day problems that may be faced by people with severe mental illness and also instructed to carefully monitor medication compliance. The weekly mental health clinics were then reduced to fortnightly visits by the psychiatrist who monitors the progress of the patients *through the RCRW* in an effort to strengthen the perception of the RCRW as the primary care provider. Follow up is ensured by the RCRW who dispenses the medication fortnightly to the patient and brings him/her for a monthly assessment by the psychiatrist.

e. ***Random Observations***

The first two phases of this pilot experience have generated valuable experimental data which will be drawn upon in planning and implementing the programme's subsequent phases. Summarised below are a few random observations and areas worthy of exploration.

1. The community tolerates the erratic behaviour of its mentally ill citizens remarkably well, as long as the individual is not aggressive and assaultive.

2. A high premium is accorded to the individual's capacity to work and earn a living. Interviews with community leaders and families of the mental ill member reveal that as long as the disabled person is able to provide for his family, any other behavioural abnormalities will be tolerated.

3. In the case of an acutely ill person, the community usually resorts to the traditional healers and religious institutions as the first line of management. Only those persons who do not respond to traditional healing methods are taken to the mental hospital in nearby Madras. This implies that the community's explanatory model of mental disorders is open to change. The professional should appreciate the central role of the traditional healer and the religious institution in the community's social support system and lay adequate emphasis on traditional systems in planning rehabilitative programmes.

4. The RCRW in any CBR programme for people with physical disabilities can take on the additional load of caring for people with mental illness provided they are sufficiently equipped in terms of knowledge and skills. This indicates the need for research to identify training methods and standardise the contents of training programmes.

f. ***Future Plans***

The pilot CBR programme has been expanded in the following manner:

1. The III Phase consists of sensitising the existing health care infrastructure. The Medical Officers and Multipurpose Health Workers (MPWs) are trained in the principles of detection and management of the same five categories of mental disorders mentioned earlier. The MPWs who cater to about 2500 population visit their communities regularly to assess general health-related problems. They are expected to detect mental disorders in an organised manner and liaise with the RCRWs for the purpose. The doctors in the Primary Health Centres evaluate the detected cases and initiate treatment. They are supported by a psychiatrist from SCARF who periodically conducts mental health clinics in all the health units in the block.
2. Towards the termination of this phase, a pilot research effort will be initiated using structured and unstructured interviews with patients, family members, community leaders, health personnel and RCRWs to assess the felt rehabilitation needs of persons with mental illness in the community. Simultaneously, a liaison effort with a mosque and a temple which have a reputation of healing mental illnesses in the Block will be undertaken. The objective of the liaison would be to undertake a joint effort whereby patients identified by the RCRWs as needing residential management will be sent to these centres with the request that they also be given neuroleptic medication. Such an effort, however difficult, may be well worth pursuing as a compromise between different explanatory models of mental illness. It is hoped that the additive efficacy of medication and social support in a culturally familiar environment will hasten social acceptance and social recovery from the illness.
3. Phase IV will require specific inputs for the severely disabled person. Vocational rehabilitative efforts need to be initiated—perhaps by sensitising the Community leaders to the need for providing vocational rehabilitation for their mentally disabled. If the initiative for such a programme came from the community itself, it stands to reason that the programme has a better chance of survival in the long term. RCRWs will be trained in simple community case management techniques which could emphasise the contribution of the family in providing a caring environment. In short, a multi-disciplinary rehabilitation programme has to be designed using extremely simple techniques which have to be devised, and its efficacy evaluated. It is apparent that the elements of such a programme will require modification as the programme takes more specific shape and will be molded by the rehabilitation needs of the community.

Conclusion

It is too premature to make more substantive recommendations. As an explanatory effort it is expected to generate more questions which research could seek to answer. It is extremely gratifying to observe from the foregoing report that it is feasible to integrate a mental health component in the framework of ongoing CBR programmes. The precise issues to be addressed would hopefully emerge in the years to come.

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Psychiatric Rehabilitation

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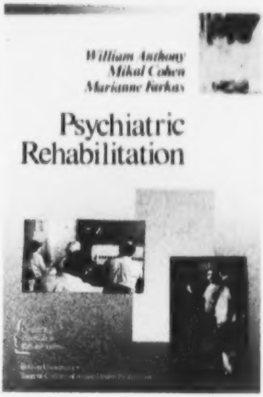

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Contents

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Rural Psychiatric Rehabilitation and the Interface of Community Development and Rehabilitation Services

Report of International Exchange of Experts and Information in Rehabilitation study-visit to India and Australia
March–April 1989

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Introduction

Life in rural and culturally-specific communities has drawn my interest, inquiry, and service for most of my twenty years as a human service and health professional. Because the rehabilitation field, as much or more so than its sister professional fields, envisions the community setting as both means and end to a successful outcome, it has been fascinating to me to work in rural communities. These communities have been in parts of the world as diverse as Maine, Arizona, and North Carolina in the US, and in Micronesia, India, and Australia. Because rural areas typically have more intact and functioning natural networks within the family and community, and also because they usually lack extensive professional resources when compared to urban and suburban communities, they offer useful studies in resourcefulness for rehabilitation service providers,policy makers, and educators.

This report focusses on community resource development,conducted for the purpose of making normative roles of living, working, socializing available to persons with mental illness that is of a disabling nature. My precise interest was, and continues to be, to identify examples of programs or projects, professional or lay, that facilitate community integration. For approximately three weeks in India, and approximately two weeks in Australia I observed activities and programs that operated at the interface of community development, rehabilitation services, and community integration. The report summarizes those observations.

A special feature of the study-visits to India and Australia were living arrangements that provided intensive exposure to life in both countries, particularly India where I would encounter the greatest contrasts with my own cultural experience. While in India I resided with four families, and spent time in the daily activities of the home, of worship, of shopping, of socializing. When not living with families, I resided in a hostel along with Indian mental health colleagues. In Australia I had an overnight stay on a sheep station, and spent considerable time in both informal and formal visits and discussions with both providers and recipients of rehabilitation services. In addition, my study-visit activities had an intensive quality. At one Indian agency, for example, I had a series of individual interviews with virtually all professional staff—and also rode a van with agency clients on a number of occasions. In Australia I had numerous in-depth discussions with groups of rehabilitation and mental health professionals, and also spent the better part of one weekend with the residents of a rural group home program.

The target audience for the report was originally intended to be service providers, to report how communities that may appear to be limited in resources may in fact be resource rich when they are mobilized toward receptivity of persons with mental illness. However, while the rehabilitation services provider is very much in mind in this report, two other key audiences emerge: rehabilitation policy makers, and rehabilitation educators. Makers of policy might consider how preparation of the community for the individual can be as important as preparing the individual for the community. Educators might consider incorporation of community development principles and skills in preparation of rehabilitation service providers.

In addition I make a case for cross-cultural learning experiences as experiences as a component of rehabilitation education (Dunlap, in press). Early in my career, while preparing to be a community development worker and teacher in Micronesia, as a Peace Corps Volunteer, one of my mentors told me that the best way to understand my country and myself was to leave familiar surroundings and live for a time in a different culture. That is an idea familiar to most persons who have cross-cultural living and working experience, but it bears repeating in the context of rehabilitation education in a pluralistic world.

Considering that this study addresses two nations, and an extensive number of contacts with professionals, consumers, family members, and daily life activities, it but summarizes observations. Persons interested in detailed descriptions of agencies and programs, in protocols for clinical or research activities,or in further cultural information, are welcome to contact me.

The method of inquiry was principally participant-observation, interview, and group discussion. In every instance where interview and discussion were used,they were accompanied by visits to program areas. Residential, vocational, social, and educational rehabilitation programs were visited, as well as community programs that combine aspects of these four areas.

Community Development and Rehabilitation

Community development and rehabilitation as disciplines or professions have developed largely in this century. Functionally, however, they are as old as humankind, dating from the first efforts of individuals and groups purposely to go about the task of creating roles and responsibilities for individuals of varying ability to contribute to their own sustenance and to the welfare of the community or group.

Since the late 1940's, with the founding of Fountain House in New York City, and particularly since the mid-1970's, the concept of the community as the ideal locus for rehabiliation services has grown in interest—to the point of mushrooming in the 1980's. Clubhouse models, such as Fountain House, (Beard, *et al*, 1982), Center House of Boston (Greb. 1983), and Horizon House of Philadelphia (cnann *et al.*, 1988), demonstrated that persons with psychiatric disability could experience successful rehabilitation outcome outside of hospital environments. It is noteworthy that the community clubhouse model has drawn international interest, and that similar programs have been established in nations as diverse as Pakistan and Sweden.

Recent endeavors to help persons with psychiatric disability to function effectively in the community include a multiplicity of models (e.g., vocational, educational, residential, and case management programs) (cf. Farkas & Anthony, 1989). One of the most effective community efforts in the USA has been the Wisconsin program of Assertive Community Treatment (PACT) (Stein & Test, 1985; the Wisconsin Program of Assertive Community Treatment (Stein and Test, 1980), Test et al., 1985), replications of which include Australia (Hoult, 1986; Hoult & Reynolds, 1984; Reynolds & Hoult, 1986). Community resource development, and coordination of the use of such resources has been identified as a significant contributing variable in rehabilitation outcome, as increasing attention is paid to the impact of environments (Anthony & Liberman, 1986; Cnaan et al., 1988). The importance of social role (Watts & Bennett, 1983), and the development of community attention, responsibility, and responsiveness to persons with severe and persistent mental illness (Farkas & Anthony, 1989; Mosher & Burti, 1989) are emerging as central concepts in psychiatric rehabilitation, as they have already to a large extent in the field of physical rehabilitation.

Two significant consumer movements stand as major influences on the new attention being paid to community resource developments. These are the patient or client movement, such as the National Alliance of Mental Patients (NAMP), and including many local, unaffiliated groups, and the family movement, exemplified by the Alliance for the Mentally Ill. Indeed, emergence of advocacy groups in these movements may herald the latest revolution in mental health services. Their importance lies in their articulate presentation to professionals, policy makers, and politicians, of the lived experience of psychiatric disability. Their interests lie not only in improved quality of treatment, but also in increased access to normative roles and to community services and resources (Hatfield & Lefley, 1987; NAMP, 1989).

Much of the world's psychiatric rehabilitation development has occured in the context of deinstitutionalization. That is, in developing rehabilitation programs, the questions are not only those of "What is the most constructive way to implement rehabilitation?", but frequently, also, "Given that there is an existing mental health system, including hospitals, how do we implement rehabilitation?" For this reason, it is instructive to look at nations which are attempting to initiate rehabilitation with and without extensive mental health systems in place. Australia and India, respectively, provide the opportunities to examine such issues, while at the same time having significant rural features worthy of study.

The India portion of the study provided an opportunity to view rehabilitation in a setting quite different, culturally, from that of the US. Given major health and social challenges faced by India, mental health has had a low priority in the national health scheme. Within mental health, rehabilitation, in turn, has had a low priority because of the pressing, if not overwhelming acute care and treatment needs of the population. With a national population now estimated at over 800 million, India has 42 psychiatric hospitals with a combined capacity of 20,000 persons, (Nagaswami, 1988) and a combined total of 2500 mental health professionals. Psychiatric rehabilitation is in the beginning stages in India, but herein lies its paradigmatic value for both nations of similar social, economic, and political picture, and those with extensive formal mental health services in place. (Asuni, 1988; Deva, 1988; Goldman et al., 1983; Kapur et al., 1975; Mendis, 1988; Orley, 1988; Pai & Kapur, 1981; Sartorius, 1988; Seal, 1984). If we were to design a rehabilitation system for persons with psychiatric disability, and rely only minimally on professional resources, what would it look like? India helps us to examine this question.

Australia has cultural similarities with the US, but has a distinct, possibly unique history of mental health services, shaped by its history of immigration and settlement. For example, mental hospitals were built in gold fields boom towns that today are small rural communities, far from major population centers, with a fraction of their goldrush populations. Vast in geographic size, but with a population of 16.5 million, Australia affords a view of rehabilitation services in a significant rural context. It is also a nation where the respective states are now taking a close look at mental health services and developing policies which will shape the nature of services for the foreseeable future.

INDIA

Context for the study visits

Two major service, research, and public education centers, and rural projects associated with these centers, were principal resources for the India visit. The Schizophrenia Research Foundation (SCARF) located in Madras, began in 1984 when a group of psychiatrists and civic-minded individuals organized to develop a community-based rehabilitation-oriented mental health service focussing on schizophrenia. Madras is located in Tamil Nadu state, in southeastern India, with a population of 50 million. The SCARF project, while based in Tamil Nadu, and undertaking a number of rural and urban prototype programs in that state, has an interest in developing rehabilitation models that may have application elsewhere in India, or in nations of the world that share social, economic, and cultural characteristics of Tamil Nadu. In February 1989 SCARF hosted an international conference on the Natural History of Schizophrenia. A major goal of SCARF is to develop replicable, low-cost models for promoting rehabilitation of persons with schizophrenia.

SCARF was my primary host in India, extending the original invitation to visit. The agency arranged my accommodations with families, and coordinated a schedule that permitted me visits to a number of rural communities, and to other rehabilitation-related projects, including the second major institution on my itinerary, the National Institute for Mental Health and Neurosciences (NIMHANS).

NIMHANS, established in 1976 and located in Bangelore, in Karnataka state, grew out of the All India Institute of Mental Health and the Mental Hospital of the Government of Karnataka which began more than 30 years ago. Over the past decade it has developed into what was described to me as the premier research, training, and treatment center for mental illness in all of India. It also purports to be the only such center with a Department of Rehabilitation. Among its many projects are an identification project to determine prevalence of mental illness in specified predominantly rural districts, and a program to teach primary health care personnel to treat and refer persons with mental illness.

Altogether, site visits in India included these two centers, two model rural projects, five rural villages, two farms, two psychiatric hospitals, a rehabilitation facility for alcohol dependency, a slum outreach project, a civic organization interested in sponsoring mental illness programs, a home visit to a family of a person with schizophrenia, a rehabilitation center for persons with developmental disability, four vocational rehabilitation projects, two community residences. By residing with families and for a brief period in a guest hostel with Indian mental health professionals, I spent time obtaining some community and professionals points of view on mental illness and rehabilitation outside of professional settings. The community living arrangements led to visits to a variety of daily community activities: shopping, worship, eating native food, family weekend outings. In the course of my visits my contacts with Indian people ranged from official discussions with leaders in rehabilitation and mental health, to riding in a van with rehabilitation program participants, to just being at home in the evening with my host families.

Findings: Programs associated with the Schizophrenia Research Foundation (SCARF)

SCARF's tri-part mission is clinical service research, public education, and research, regarding schizophrenia. From modest one-room beginnings in 1984, the organization's present scope is local, regional, and national. In the local and regional area SCARF endeavors to design and deliver service to individuals and families, evaluate outcome, and disseminate results to professional colleagues in India and elsewhere. This is an organization which sends psychiatrists and other mental health professionals directly to rural villages, and to urban slums (both of which I visited); as well as to national and international conferences on rehabilitation and mental illness. The day-to-day clinical and community activity of staff who are also engaged in research and public education makes for a rich experience base for all three parts of the mission. Such a combination of roles is probably rare in the US where specialization is the rule.

It is noteworthy that SCARF focuses on schizophrenia, certainly one of the most disabling of mental illnesses, because community mental health programs in the US have come under criticism for putting a disproportionate amount of effort and funding into less disabling forms of mental illness. Focussing in this way, SCARF can target its research and education activities, and avoid the dilution of its efforts which might occur if it attempted to address all forms of mental illness. Further, it presents schizophrenia as a specific, recognizable illness, with a biological base, responsive to medical and rehabilitation measures (Nagaswami, 1988), and thereby attempts to remove some of the mystique often associated with mental illness. SCARF recognizes that there are indigenous explanations of mental illness, such as possession, that can cause a family or individual not to seek treatment or to conceptualize rehabilitation as possible.

SCARF's leadership regards the major mental health challenge in India as "the lack of a suitable, cost-effective model for use in a developing country" (Nagaswami,1988b). Although there are exemplary mental health projects in India, in the view of SCARF authorities only a very small number of persons in need of service are receiving service. The prospect of a Western-type mental health system being developed in India, with a network of community mental health and inpatient facilities, is not realistic because of funding and human resource constraints. Further, given the criticism of deinstitutionalization in the West, particularly the failure to provide appropriate community support and services, on conceptual grounds, let along logistical grounds, Western models may be inappropriate.

A major SCARF endeavor is "development of a suitable rehabilitation model which will be need-based, rurally-oriented, cost effective, easily replicable, dependent on minimal professional inputs, and be capable of being integrated within the existing mental health infrastructure without overburdening it" (Nagaswami, 1988b). India is a signator to the Alma Alta Declaration of "Health For All BY the Year 2000", and has developed a National Mental Health Program which recognizes the necessity of rehabilitaion interventions at the local community level, and for community development that engages existing community services in the rehabilitation effort, and disseminates information on psychiatric illness throughout the populace (NHMP, 1982).

A community-based, rural rehabilitation project undertaken by SCARF in conjunction with the International Red Ross is the Community-based Rehabilitation Project (CBR Project). Key to the project is a community-based rehabilitation worker, who is a volunteer identified by village leaders. The US counterpart to the CBR worker is a case manager, except that the India worker is selected for knowledge of the community, and respectability from the community. Volunteers receive a token amount of fifty roupees per month. They accompany the SCARF psychiatrist during rural clinic sessions, and provide the psychiatrist with information on the family and community functioning of service recipients. In the community, the worker monitors the use of medication, as the lack of adherence to medication regimes, particularly in remote areas, is a major obstacle in the treatment of mental illness. Education of individuals and families is a critical function of these workers.

Beyond these clinical and education functions, the CBR worker acts as a consultant to the community, with the purpose of identifying appropriate, contributory roles in family and community for service recipients. In SCARF's view, a rehabilitation model utilizing local community volunteers may be more suitable than one relying on primary health care personnel, as the latter are heavily burdened with tasks including infectious disease and family planning, and do not have the time to engage in community consultation.

A CBR Project I visited was in the Tirupur District, south of Madras. I accompanied the SCARF psychiatrist and the CBR worker to three rural sites. The clinic was held in whatever space was available, usually one room with a table and folding chairs. Special to these visits was the accompanying of the individual to the clinic session by family members, as well as the rehabilitation worker. Prospects for continuity of care appear excellent in such circumstances. Although the cultural context facilitates such participation and continuity, it is as aspect of service that bears noting by American rehabilitation and mental health personnel given the concern in this country about continuity of care.

Related to the CBR Project is the endeavor of SCARF personnel to develop linkages with community leaders, and with local respected healers and helpers. On one visit, our team of psychiatrist and CBR worker stopped at the village of Kovalam, where a Muslim holy man maintained an outdoor soup kitchen. He spoke about encountering a number of persons with mental illness, and he and the psychiatrist discussed the needs of such persons, and ways of responding to those needs. Out of these discussions came an agreement to make cross-referrals—a fine example of professional and community collaboration toward a rehabilitation effort.

Two case examples from the Tirupur project indicate the potential of this community-development rehabilitation model. In one case a thirty-five year old woman who had been diagnosed with schizophrenia for seven years, was brought to the rehabilitation clinic session by her husband and mother-in-law. In the past she had been treated episodically at a psychiatric hospital in Madras, and at a general hospital, also in Madras. However, she had been non-compliant with medication because the family lacked financial resources for travel. Also, because her husband was employed as a fisherman, it was financially extremely difficult for him to leave his work to make the trip to Madras. The CBR worker was able to facilitate medication compliance in consultation with the psychiatrist, and to consult with the family on helping this woman to be productive in her family.

Another example is that of an eighteen year old young man brought to the rehabilitation clinic at the encouragement of the CBR worker. This young man had first been seen only six months ago. His diagnosis included "behavioral disorder" and he is under continuing observation for diagnostic purposes. Before coming to the clinic he had been tied up by his family to prevent him from wandering off while they were working or otherwise away from home. After three months of contact with the project, he was untied, with his family now using a twine leash and taking him out of the home more often. He was accompanied by his mother and paternal grandmother. The original, almost desperate, restraint measures are now giving way to a gradual venture into the community.

Yet one more example of this community-based approach comes from one of the SCARF urban slum projects. A woman of unspecified age diagnosed with schizophrenia was helped to start a modest business selling vegetables. When she has an acute episode, her neighbors sell her vegetables for her and give her the money, which makes it possible for her to continue to live with her family. When I visited this project the psychiatrist remarked to me that "The poor are the most supportive of one another of all the people we see." SCARF recognizes the delicate, but essential nature of this helping tradition, and in its community-based rehabilitation approach, it seeks to maintain these existing support traditions, and avoid supplanting them with less effective professional structures and services.

The SCARF CBR Project is a major community development oriented project. Worthy of mention are other community endeavors being pursued by SCARF, all of which I visited. These include sponsoring a family group called AAHSA which means "hope" in the Hindi language. This group bears some similarity to Alliance for the Mentally Ill groups in the US. It operates without professional leadership, and SCARF's role is to support its development as a community resource, with the plan for the group eventually to sever formal ties with SCARF once it has become more established and increased its membership. SCARF also has developed a relationship with two institutions of higher education that offer a social work degree, the Madras School of Social Work, and Stella Maris College, for the purpose of incorporating psychiatric rehabilitation information into their curricula. Hosting of professional workshops, and recruiting public support through presentations to civic organizations such as the Roundtable, are examples of SCARF's endeavor to bring schizophrenia to the attention of a broad spectrum of the community.

The National Institute for Mental Health and Neurosciences (NIMHANS) and affiliated programs

NIMHANS directs a sophisticated and extensive clinical, research, and professional training effort. Its services include units for inpatient service, outpatient community mental health service, a family therapy program offering live-in family units, and a rehabilitation unit that emphasizes vocational rehabilitation within the hospital setting. Described to me as the premier mental health facility of its type in India, NIMHANS, in Bangelore, is a major tertiary care facility, as well as a community mental health service. So extensive are the programs of NIMHANS—from studies of indigenous Ayurvedic medicine to neuroscience, from inpatient whole family treatment to community outreach to remote, rural communities; it is tempting to try to describe all. However, NIMHANS efforts are well-documented in its own professional journal (cf. Reddy et al, 1986) and newsletter (cf. Murthy, 1987), and it has published a near book-length summary of its first decade as now organized (Reddy, 1986). Accordingly, this report focuses on community development activities of NIMHANS.

A major community-oriented endeavor is piloting and implementation of the use of Multipurpose Health Workers. These workers are the village-level providers of health care and health education. Because they are tied to a district and regional network of physicians and other health care providers, potentially they are well supported for consultation and referral purposes. Historically, mental illness has not been a major focus of these workers, nor of the primary health care system in general. Accordingly NIMHANS is undertaking the orientation of primary providers in the identification and treatment of mental illness (Isaac et al, 1985). A component in this community endeavor is public education, and pictorial materials illustrating symptoms of mental illness have been designed for instruction and distribution, so that the public will approach health personnel for treatment of the illnesses so illustrated (Sekar, 1987)

Examples of demonstration projects are those at Sakalawara, a rural community twenty kilometers outside of Bangelore (Isaac, 1986), and at Bellary District (Isaac, 1988) a district of approximately 1.5 million population.

Sakalawara was the site of a feasability study between 1977 and 1980, involving an extensive rural sector of 122 villages with combined population of 76,000, in the use of primary health care personnel for mental health purposes. Following promising results in Sakalawara, a project began in Bellary District in 1983. These education and outreach projects endeavor to use existing personnel, already in place, rather than create an additional mental health infrastructure. There is also an effort to enlist local community leaders as allies in the program, as recognition of the validity of this outreach program is essential.

The NIMHANS and SCARF approaches to community-based services have similarities in that both seek to use a combination of public education, collaboration with local leaders, and incorporation of a mental illness focus into the work of outreach personnel. Differences appear to be in SCARF emphasis on rehabilitation through a community-based worker, i.e. the assumption that primary treatment must be followed by monitoring and support of proper compliance with treatment, and that families and communities may require some education and consultation in how to make some normative roles available to persons with serious mental illness. The NIMHANS approach works through an existing and extensive primary care network, with health care providers who would appear to be well-received by the community. It appears to be an assumption of this approach that rehabilitation may be delivered by families and community without much on-site consultation, because there are existing traditions of care, particularly in rural communities.

There are good arguments for both approaches. It is to the credit to both NIMHANS and SCARF that they conduct program evaluation research. Accordingly, outcome data may help to determine the appropriateness of either approach or combinations of the two.

A number of other community-based efforts of NIMHANS are worth mentioning. I visited the Vocational Training Centre for the Handicapped in Bangelore, a center started by an industrialist who has a family member with a psychiatric disability. Significant is the involvement of a businessperson in creating a vocational rehabilitation center. At the center, employees produce goods for the open market, in what is a kind of enclave supported employment model. Another vocational project is operated by Friends of NIMHANS, a group of volunteers that make space available in a home for productions of household goods and office supplies. I also visited a half-way home and hostel operated by the Medico-Pastoral Association, a charitable organization. These are all significant developments, all receiving encouragement and various kinds of institutional support from NIMHANS. Their significance lies in the recognition by NIMHANS that vocational and residential rehabilitation in community settings, run by lay people, is a vital, effective component to mental health services.

The opportunity to visit farms, and rural villages, and to spend evening time with staff and their families, was exceptional, providing me with an appreciation of the cultural context of rehabilitation services. A very memorable experience was a home visit in the Bangelore area, made by taking a series of buses one evening and walking through a number of neighborhoods to call on the family of a 48 year old man diagnosed with schizophrenia. I was accompanied by a NIMHANS social worker on the visit, and, with a 17 year old young man as the informant, we were able to consult with the family, and with one another on the rehabilitation potential of the family member. Other NIMHANS activities included participating in a clinical case conference, and in numerous group and individual sessions discussing concepts of rehabilitation. These provided an inside view of rehabilitation efforts of NIMHANS.

Summary

India is including mental illness in the "Health For All by the Year 2000" World Health Organization effort. My itinerary included two leading organizations that are developing model responses to rehabilitation needs of persons with disabling mental illness, one a non-government organization focusing on schizophrenia, the other a government-supported major mental health clinical, teaching, and research center. The former is field-testing a community development approach involving the use of community-based rehabilitation volunteer workers. The latter is pursuing a primary care model based upon the addition and incorporation of mental health identification and treatment into the role of health workers.

I met with some of India's outstanding leaders in the psychiatric rehabilitation effort. By virtue of family and hostel accommodations, and the thoughtfulness of hosts, I enjoyed very instructive exposure to Indian family and community life. Also, I had some direct contact with service recipients through home visits, conjoint interviewing, participant observation in group work, and community visits.

India clearly faces a formidable psychiatric rehabilitation challenge. On the basis of my study-visit observations it appears that mental health and rehabilitation leaders are attempting to develop a useful combination of modern and traditional principles and practices. Family and community integrity is to be respected and supported, while modern methods of rehabilitation and medicine are selectively applied.

Particularly noteworthy in the context of community development were efforts to use existing community resources in a rehabilitative way, examples being existing health and rehabilitation personnel, village leaders, industrialists and other employers, clergy, indigenous medical providers, civic organizations, family members. These endeavors, which may be characterized as mobilizing the community to support the individual, as well as the individual to adjust to the community are very much in the forefront of international rehabilitation efforts. The fact that demographic, evaluation, and consumer research is being conducted as standard component of program development makes these endeavors all the more impressive.

AUSTRALIA

Context of Australia Study-visits

Australian mental health policy is largely determined by various state governments. While in Australia for slightly more than two weeks I visited services, and policy and training centers, in the two states of Victoria and New South Wales. Serving both as host for the Victoria portion of the study-visit, and as coordinator of the overall Australia itinerary, was the Staff Training Team, Office of Psychiatric Services, Health Department Victoria. My host in New South Wales, who also welcomed me to Australia, was the Mental Health Staff Education Unit, Department of Health, New South Wales.

While these two Australian states were called to my attention as the nation's most active in psychiatric rehabilitation efforts, they appear to be pursuing different means to reach the goal of having effective rehabilitation services. As was the case in visiting programs in India that are approaching community-based services differentially, it was quite instructive to view the approaches of these respective states.

Historically, Australian mental health services have reflected a Western, particularly British, influence. The deinstitutionalization movement of the 1960's and 1970's in the West has touched Australia, and by the late 1970's attention began to the need to provide an effective transition to the community for persons who had been institutionalized, as well as a new, a-institutionalized service population. A major figure in the community-based, rehabilitation effort has been John Hoult who has pioneered and promoted the concept of community transition teams (Hoult, 1986; Hoult & Reynolds, 1984; Reynolds & Hoult, 1983). Conceptually, the work of Watts and Bennett of Great Britain in applying principles of rehabilitation to psychiatric disability (Watts & Bennett, 1983); and of Stein and Test of Wisconsin in the US regarding community case management and treatment (Stein & Test, 1985) have been important influences. The 1980's have emerged as a time for policy formulation, based in part upon the effectiveness of early community and rehabilitation efforts.

The State of Victoria

Victoria is Australia's second most populous state, at 4.3 million. Located in the southeast corner of the continent, it is second to Tasmania as the smallest state, but is small only by Australian standards. Geographic area is nearly 90,000 square miles, slightly larger than the US state of Minnesota. The rural character of much of the state and nation is illustrated by the fact that Melbourne, the state capital, has a population of three million.

My study visit to Victoria was both intensive and extensive. In seven days I visited three rural areas of Warnambool, Sheppardton, and Beechworth, as well as policy and training centers in the greater Melbourne area. The itinerary was thoughtfully arranged to provide time to speak individually with service recipients, family members, community program staff, hospital staff, and policy personnel. Among the highlights of the Victoria experience was spending a weekend with residents and staff of the Gilcrest Group Home in Beechworth, visiting a community transition program associated with Brierly hospital in Warnambool, and participating in the quarterly "country forum" —a gathering of rural service providers—in Sheppardton.

A noteworthy aspect of the history of mental health services in Victoria is that a number of asylums were built in gold rush boomtowns in the eighteen hundreds. A century later these former population centers typically are rural, sometimes remote, communities. Beechworth is one example, where the Mayday Hills Hospital was built in 1867 as a lunatic asylum for 400 persons. The census rose to a thousand at the height of gold fever. Today Mayday Hills has a census of approximately 200, and Beechworth itself a population of 3800.

Consideration of community-based rehabilitation services in Victoria, as in much of Australia, means changing the role, and perhaps the existence, of inpatient facilities that may be the principal employer in a rural community. Herein lies a difference between India and Australia. In India the need for services far outstrips the availability of services. However new they may be, rehabilitation-oriented services in India do not replace existing services. In Australia, however, community-based rehabilitation may represent or require re-allocation of resources. This is a circumstance that presents policy makers with community socio-economic and political variables to consider, along with rehabilitation outcome variables. Accordingly, the Victoria and Australia psychiatric rehabilitation effort is concerned not only with model building, but also significant system change to accommodate new models.

Mental health services in Victoria have these major components: state operated hospital; community mental health center, and specialist service system psychiatric units in general hospitals; private practitioners, and the emerging not-for-profit organizations whose usual focus is community settlement and rehabilitation. This composition of services is similar to that in the US, but without the component of a private psychiatric hospital. A shift towards community treatment has resulted in a marked reduction in the average length of stay per hospital admission, but re-admission of previously discharged persons has now become a paramount concern.

Victoria studies have shown that fewer than half of those admitted to hospitals have had benefit of community-based assessment to determine whether community alternatives might be utilized. A 1985 study indicated that between 8–19% of persons were readmitted within ten days, and 24–42% within six months. These findings have suggested to Victoria authorities that a need exists for continuity of care such that appropriate, supportive services are available for persons once discharged (Rimmer, Buckingham & Farnhall, 1988).

Site visits in Victoria included the Richmond Fellowship, a non-government organization (NGO), operating with staff support from the OPS, and sponsoring a range of rehabilitation-oriented residential and day programs. A visit was made to Larundel Hospital in greater Melbourne for discussions with mental health professionals, for meetings with clients in a psychosocial disability unit, and observing components of a de-institutionalization effort that includes converting former staff residences to client residences. Victoria has just completed the "decommissioning" of Willesmere Hospital in Melbourne, and reallocated the former hospital's funding to community services, in what appears to be a demonstration that the transition from a hospital-based system to a community-based, rehabilitation-oriented system is, in fact, possible.

Additional site visits were to the rural communities of Warnambool, Sheppardton, and Beechworth, where inpatient units are located either because once these were more populated areas, or because they were constructed in this century to accommodate the growing demand or "overflow" for inpatient services for Melbourne-area individuals. Today, residents of such institutions tend to come from communities far removed from these rural institutions. Brierly Hospital in Warnambool has developed a network of fourteen community residences, and a rehabilitation program to prepare residents for them. These fourteen sites vary in the degree of supervision provided; accordingly it is possible to arrange a match between the functional residential abilities and rehabilitation needs of individuals, and the environmental demands presented by the sites. At Mayday Hills Hospital in Beechworth, a similar development of community residences, with rehabilitative support services, has begun. A special feature of the Beechworth visit was the opportunity to spend a weekend with the residents of the Gilcrest Group Home. The Sheppardton hospital was the site of the Country Forum, which rotates among rural host sites.

In addition having contact with professionals and service recipients. I met with a representative of the Schizophrenia Fellowship of Victoria, and the Schizophrenia Forum of Australia. These are family organizations, developed along the lines of the Alliance for the Mentally Ill in the US.

Victoria Findings

Reviewed in this section are a series of exemplary policy and program developments in Victoria State. These were selected for their relevance to the community development theme of the study.

The Office of Psychiatric Services, Health Department Victoria, has identified seven "Strategic Themes in Service Redevelopment" (Rimmer, Buckingham, & Farnhall, 1988). These themes include development of a client need-based service system, in which services will be created in response to assessed needs, instead of referring clients to existing services simply because those services are already in place. Other themes are: continuity of care; the community as the locus of rehabilitation; focus on specific client outcome from using a service; and developing service alternatives. One theme of particular interest for this study is that of mobilizing community and political support to address isolation and stigma associated with mental illness, and to open up to persons with mental illness the range of formal and informal community resources and services available to other citizens.

The Staff Training Team (STT) of the Office of Psychiatric Services has been organized to provide the staff training and support underpinnings of the policy and program developments that flow from the above themes. Located in Parkville, in greater Melbourne, the STT sponsors programs throughout the state with emphasis on assistance to staff of new mental health services. One example is the Country Forum, the quarterly meeting of rural service providers. I attended this Forum, at which staff of various rehabilitation-oriented programs made presentations, in a peer sharing and networking format. A second example is the psychosocial rehabilitation training workshops which are scheduled for September and November 1989. These will offer training in principles and practices of rehabilitation. Such a linking of professional in-service training with policy development is logical, but in the US is more the exception than the rule.

The planned, progressive reallocation of resources from hospital to community is a third finding. As indicated earlier in this report, however bold reallocation may be, and however encouraging from a rehabilitation point of view, it has risks. In Victoria a paced approach is in place using one project, the Willsmere decommissioning, as a learning experience, and then gradually examining the feasibility of similar changes in other institutions.

Yet another finding comes from participant observation: that when clients become citizens of communities and regard mental health service providers as supportive of their rehabilitation goals and efforts, it becomes apparent that the normative tasks in the community have great rehabilitation potential. Having control over one's living space, shopping, traveling, engaging in recreational activities in the community—represents a paradigm shift in both how persons with psychiatric disability are viewed by others, and how they view themselves. While visiting the Gilcrest Group Home in Beechworth, I joined the residents on a Saturday rappelling activity, and observed a 50-year-old man—who had been an inpatient for nearly half of his life before being given the opportunity to live in the community home—do the first rappel of this life, three stories high. The potential of this kind of outdoor activity, and of dozens of other normative activities, indoors and out, have yet to be explored with this population.

Summary

Participant-observation in Victoria yielded findings of a planned, gradual development of community residential and social-recreational resources. In part, hospital facilities, such as residences formerly used to house staff, funds, and staff are resources for this community development shift. But also, the opportunity to utilize existing services, resources, and activities of the kind that are available to all citizens, is being explored. Interest is high in international developments such as the programs at the Center for Psychiatric Rehabilitation in Boston. Staff training is underway to provide concept and skills supportive of the transition. Forums exist to facilitate the peer sharing of support around various pioneering community rehabilitation ventures.

The State of New South Wales

New South Wales is the most populous Australian state, at 5.7 million. The greater Sydney area contains approximately five million of that number. The next smallest state after Victoria, at 309,000 square miles, like its neighboring state 'small' is quite relative for it is over half the size of Alaska! Once one leaves the Sydney and coastal areas, there is the broad expanse of bush and outback that stretches west a quarter of the distance across the continent. New South Wales is the site of the first European settlement, in 1788, celebrated one year ago in Australia's bicentennial (Hughes, 1987).

As in Victoria, hospitals or asylums, built on a British model, were, until recently, the core of the mental health service system. In the early and mid-1980's through the efforts of John Hoult, Alan Rosen, and others, the use of community teams, and of community residential, vocational, and social recreational resources was undertaken and evaluated, in the North Shore area, immediately north of Sydney (cf. Hoult, 1983). In 1982 the state government established a committee to examine the state of existing services for persons with mental illness, and developmental disability, and to make proposals for state policy. This report, dubbed the 'Richmond Report' after its chairperson, recommended the separation of psychiatric and developmental disability services, and a shift from hospital care to supported community rehabilitation as the emphasis in services.

In the mid-1980's the execution of a series of Richmond Report proposals resulted in transfer of 208 long-term patients to community residences from psychiatric hospitals, the purchase of 125 community properties, mostly for residential purposes, establishment of 39 living skills centers, and establishment of 12 crisis intervention teams (Mental Health Services Unit, 1988).

Subsequent reviews and recommendations called for an eight-year plan beginning in 1987 that included community-based service as its primary objective, and promised to close five psychiatric hospitals. However, the issue of hospital closures proved to be controversial enough that it became a political issue in elections held in March 1988, which brought a new majority party into government.

The Richmond Report-related program developments were generally halted. A new review committee was constituted to review anew the services to persons with psychiatric disability and developmental disability. The report of this group, dubbed the 'Barclay Report' after its chairperson, recommends a central role for hospitals both for treatment and rehabilitation, and for administrative and staff supervision control over community mental health services (Mental Health Services Unit, 1989). The Barclay Report was submitted to the Minister for Health in November 1988, and information sheets summarizing its recommendations were published in Februrary 1989, only two months prior to my visit.

Accordingly, my visit to New South Wales occurred during a period of policy change so new that full impact has yet to be felt. In this context I visited what appeared to be exemplary community-based rehabilitation services—the result of the few hospital-to-community program transitions in the early and mid-1980's. I also met with those who foresaw the return of hospitals to a central role, as proposed in the Barclay Report. Yet others said that the community movement would proceed and that the language of Barclay provided a politically acceptable description of what was to have happened pursuant to Richmond. These developments provide opportunity for an intriguing case study in systems change, comparing and contrasting the Victoria and New South Wales experiences. Such a study is beyond the scope of this report as it is still very early in the process for both states.

One footnote to this period of change is the announced plan to phase out the Staff Education Unit of the Mental Health Services Unit, of the Department of Health. This Education Unit was my host agency for NSW visits. As opposed to having a state-operated unit to provide training and technical assistance to staff engaged in community services development and delivery, a new staff education scheme calls for universities to be the primary vehicles for in-service mental health training. This state and university collaboration in support of training for rehabilitation-oriented program development is a model in use in my home state of Maine, and through the rehabilitation education program in which I teach (Dunlap & Wygal, 1989). It is, however, the exception rather than the rule in the U.S. for a university to have major staff support functions. I did not visit any university units in NSW that were preparing to discharge this function.

My visits in NSW included the Staff Education Unit, where I was updated on the history of rehabilitation efforts over the past decade, including the North Shore demonstration projects, and the Richmond and Barclay

Reports. I visited the North Shore Project, which is very much in operation. Given my rural interests, a very instructive and enjoyable part of the itinerary was a two-day visit to the town of Orange, 260 kilometers west of Sydney. Orange is home to Bloomfield Hospital, and to an exemplary community development and rehabilitation project. Titled 'SHIPS', for the 'Satellite Housing Integrated Programmed Support' program, this endeavor enables persons with disabling mental illness to live in the community with choices from a range of residential options, varying in the amount of supervision provided. As in Victoriak, I participated in a number of forums and discussion groups, formal and informal, during my time in New South Wales.

I was very fortunate, and very grateful, to be the overnight houseguest on a sheep station in the Orange area. This experience afforded a glimpse into rural Australian life, and the values exposed in rural communities. Accordingly, the New South Wales visits offered contact with demonstration projects of national prominence (and in my view, international significance); with staff and service recipients; with families; and with service recipients. My participant-observation experiences included making an evening home visit to a home shared by three service recipients, having meals with residents of other programs.

New South Wales Findings

The SHIPS project is an exemplary rural psychosocial rehabilitation program. In essence the program uses the community as the locus of rehabilitation, and provides staff to assist program participants to function effectively in the community, with staffing patterns and interventions designed according to the skill needs and support or supervision needs of individuals. For residential rehabilitation, the program includes use of residences purchased by the government. These are ordinary homes usually with a minimum of three bedrooms. They are selected to be uninstitutional in appearance, and are dispersed throughout the Orange area. Residences vary in the amount of staff support provided, varying from 24-hour coverage to once per week contact. It is not required that these residences be the only options; private apartments or 'private accommodation' as it is called, is possible as a logical part of residential choices. The program operates according to the principle of 'least restrictive alternative', although that particular term was not used.

Social, vocational, and educational rehabilitation services are delivered by using existing community services open to all citizens. For example, adult education services may be used. The program does sponsor a crafts-oriented center, as a day activity. However, in keeping with program philosophy, it is optional, and participants choose from their own hours and activities, and arrange their own transportation. One rural residence has a seedling business, and conducts some subsistence gardening and sheep raising. use of social services is encouraged; during a visit to one of four homes in the community, I met outreach persons from a church-related program. Most residents and participants in SHIPS are individuals formerly inpatients at Bloomfield Hospital, most of them long-term.

The North Shore project operates with a similar philosophy to that of SHIPS, offering a range of residential options for persons who historically have been long-term, impatients in state-operated psychiatric hospitals. One difference is the operation of a Living Skills Center which services multiple functions: drop-in center; site for pre-vocational programs; social and vocational skill training sessions, and individual problem-solving, goal setting, and assessment services. The Center has work crews as part of its vocational rehabilitation programs. These crews perform various maintenance jobs in the area.

While SHIPS generally relies on existing community services, the North Shore has this Center as a resource. Noteworthy is the combination of 'low demand' and 'high demand' access to the Center. Low demand programs have as their goal developing trust and confidence; an example is 'drop-in' time, when persons may come to the Center and do as much or as little as they wish. Other times of each day are set aside for structured activities, such as skill training sessions, and at least some of these last for a specific number of weeks. Such high demand times are designed to respond to the skill and support needs of persons ready to move ahead in the rehabilitation process. Having witnessed the low versus high demand philosophy debated in the U.S., the combination of the two in one center is a logical, but perhaps overlooked solution.

Quite apparent in both SHIPS and North Shore is a service philosophy that builds a rehabilitation response around the needs of the individual. While meeting individual needs has become virtually professional jargon, in these programs one is impressed by the options available, and by the commitment to assist program participants to make choices, and to help them to attain the goals inherent in their choices.

For rural communities, SHIPS is a useful model. Focus of the model is on community support services to participants, and to community agencies and individuals who are actual or potential resources. It represents a king of rehabilitation without walls. Participants learn how to live in the community by living there, with staff support. Their residences look like the other residences in the neighborhood. If they wish to pursue vocational, educational, social, or recreational interests, they are aided in using the resources of the community to do so.

Financing of community-based programs such as those I visited has been achieved largely through reallocation of hospital budgets. Some interim additional funding may be required during the period when new community-based services are being planned, but Bloomfield, in particular is an example of a successful reallocation project.

However creative reallocation is from a funding standpoint, it has opponents. As I did in Victoria, I encountered employees of the mental health system who feared for the loss of their jobs if Richmond-style proposals were to proceed. In the community the perception of persons with metal illness as dangerous persists. At least one community residence I visited was greeted at its opening two years ago by violent demonstrations. As indicated earlier in this report, concern over the discharge into the community of large numbers of dangerous individuals was reported to me as being an issue in state elections one year previous. But, in turn, the SHIPS program n the rural Orange area is described by its proponents as having been accepted by the community.

Summary

It appears that in New South Wales working models for community-based rehabilitation services have been developed, and evaluated as effective for their target population—persons with severe and persistent mental illness with long institutional histories. A series of issues now to be addressed concern systemic developments, such as the role of inpatient facilities; the nature and size of such facilities should they continue; rehabilitation competencies required of mental health service providers, and the pre-service and in-service training structures necessary to deliver these competencies; and management of professional and public reactions to any systemic change in how service is delivered.

Implications For Psychosocial Rehabilitation in the United States

Two major questions arise from the study which are pertinent to rural rehabilitation efforts in the U.S. The first question arises from the India context. It is how to deliver services of quality to unserved and underserved populations, who live in areas with minimal or non-existent professional mental health and rehabilitation resources. The second question, which arises from the Australia context, is how to accomplish the systemic transition to community and consumer-oriented rehabilitation services, once the effectiveness of model projects has been established. This is not to categorize rigidly either nation, however, for both face both issues, but with a different emphasis at this time. For India, as well as Australia, has a network of psychiatric hospitals, general hospital psychiatric units, and private mental health practitioners. And Australia, as well as India, has unserved and underserved persons, with persons from non-English speaking ethnic backgrounds being one example, persons in thee vast rural outback being another. The U.S. rehabilitation and mental health communities face these issues as well.

One of the points made by Indian mental health leaders is that the effort to develop community-based, rehabilitation-oriented services is not only a funding or resource issue. It is an issue of effective service. The American mental health services experience is hardly viewed as a success, with its reliance on institutions, its separation from medicine, social service, and rehabilitation; its professionalism and professional rivalries; and its limited response to the needs of culture-specific persons. India hopes to do better by not imitating the West.

The paradigm issues raised in Australia, at least that dialogue exists. One of the frustrations of the U.S. rehabilitation community has been the difficulty in getting state mental health departments, the mental health professions, and institutions of higher education to even acknowledge the validity of rehabilitation for persons with mental illness. In spite of a sizable and growing research base supporting rehabilitation practice (Anthony & Dion, 1988; Anthony & Blanche, 1989), it remains a fringe, rather than a central philosophy and practice in American mental health. It has been the family movement and the consumer movement in the U.S. that has been most forceful and effective in moving rehabilitation issues toward the center stage, not established mental health professionals and entities. The Australia experience should prove instructive, not only for the underserved rural areas of the U.S., but for the nation as a whole, in terms of how to implement a rehabilitation philosophy.

The following are specific implications for rehabilitation policy makers, rehabilitation educators, and rehabilitation practitioners, particularly those concerned for rural areas, and for the application of rehabilitation principles and practices to mental illness.

- Psychiatric rehabilitation is a worldwide interest and movement. It is useful paradigmatically and practically to exchange views and information with international colleagues. This may be accomplished by attending to international publications; soliciting contributions from international colleagues; actively encouraging presentations at professional conferences on international perspectives and programs; promoting exchanges of policy makers, practitioners, and educators.
- Of particular value during this series of study visits were opportunities to obtain the points of view of consumers of services, and of families affected by mental illness. It does not require international travel to do this. Consumer organizations and family organizations exist in every state in the U.S. They should be consulted on program development, invited to professional gatherings, and invited to university classes and to professional in-service education programs, to present their perspectives.
- The family live-in experiences were extremely instructive regarding the cultural and community context on services. Such experiences can be arranged in the U.S. They should be a standard component of rehabilitation education. International live-in experiences offer the perspectives on culture, values, and behavior that come from stepping outside of one's own milieu. For rehabilitation educators, these are recommended.

- Community-based rehabilitation services of residential, social, vocational, and residential nature have been demonstrated as effective for persons with mental illness. These services require community development competencies that may not ordinarily be included or emphasized in rehabilitatoon education, such as public education to eliminate stigma, enlisting the political and financial support of public officials and business leaders, using electronic and print media, networking and lobbying with social service agencies to serve persons with mental illness; creating housing, job, social, and educational opportunities; networking with resources that are used by consumers, but perhaps not ordinarily viewed as resources by practitioners, such as clergy; networking with consumer and family groups.
- The most effective rehabilitation efforts I observed were in the community. Practitioners ought to view the community as the work milieu. Professionalism tends to assign higher status to those in the office, than to those on the street, and this orientation needs be be reversed.
- 'Resource-poor' communities ought to be viewed as potentially resource-rich. If the disability-handicap paradigm is applied to communities, it is unfair to label communities. Whether a community has resources is not the issue; rather the issue is how resourceful are the rehabilitation practitioners. This is particularly poignant in rural communities where many informal resources—family, employers, social and civic organization, clergy, health care personnel—await the community development skills of rehabilitation practitioners.
- Social, recreational, and personal-growth enhancing activities used by the general public can be applied to this population. The rapelling and trekking observed in Australia are examples. Indian examples include gardening, and dramatics.
- Research into rehabilitation outcome, family and consumer views of service, and identification of target population are all inquiries urgently needed in the field. Competencies for conducting such research should be in rehabilitation education curriculum. Certainly there should be in rehabilitation education curriculum. Certainly there should be plenty of programs in the field available for rehabilitation students to practice and apply their research competencies. It was impressive that such research was an integral part of services in India.

A Final Word

Some very powerful images persist from this study visit. I recall the eagerness of a community-based volunteer rehabilitation worker at Tirupur District in Tamil Nadu; children bringing a parent to a rural clinic outside of Madras; a home visit with an Indian colleague in Bangelore; a 50-year-old former backward patient doing a rappell in Victoria;l a 32-year-old 'hopeless' patient living in his own apartment in Melbourne, no longer hiding in the hospital laundry; another former long-term inpatient preparing the evening meal in a New South Wales rural group home, with a view out the kitchen window of sheep country, stretching to the horizon. These are powerful and moving images of individual and community potential. Clearly, there is much to be learned from the East.

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DIRECTOR OF REHABILITATION SERVICES

Director of Rehabilitation Services needed to coordinate and supervise rehabilitation services within a community based mental health agency located in upstate New York. Responsibilities include supervision of programs and staff that provide vocational training to adults and adolescents, liaison with community and state agencies and business community, and direct services to include vocational assessment and job development. Qualifications: Masters Degree in Vocational or Rehabilitation Counseling with experience and/or training with psychiatric population. Salary is $24,000 to 26,000 based on experience. Please submit letter of application and resume to Sara Rowden, Associate Director, Northern New York Center, 63 Broad St., Plattsburgh, N.Y. 12901. (518) 563-1160.

Book Reviews

Anthony M. Zipple, Sc. D., Book Review Editor

Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents

Ann Vernon. Research Press, 1989, 243 pg., $25.95.

Imagine you work in a psychosocial program. You have been given the task of designing and implementing a program to teach positive mental health concepts to adults with psychiatric disabilities. What do you do?

Do you shift into your creative mode and begin that arduous but personally fulfilling process of program development? First there is figuring out what concepts fall into the category of "mental health" concepts. Then there are decisions to be made about process and content. There are lesson plans to write and staff to be trained. All this time you are wondering if this product you've spent countless hours developing will accomplish your pedagogical objectives. So you test it to see if it works.

In the midst of all this creative fervor, you begin to wonder if you are simply reinventing the wheel. Your alternative is to use "prepackaged" programs. The problem is deciding which one will do. Having faced this problem in the past, I have a few guidelines I use when choosing a "packaged" program. The first point is that the stated purpose/outcome of the program must correspond to my program goals. If I am looking for a program that teaches skills, I am not going to choose a program that does not assess skill performance.

Secondly, the material has to be relevant to the people learning it. It should be appropriate to the abilities and the disabilities of the learners. I will allow for adaptability. If the program is designed for adults of average intellectual ability, can it be easily adapted for adults with developmental or learning disabilities?

My third criteria is that the program be user friendly. That means: (1) the directions for using the program are clear and easy to understand; (2) the material is presented in a logical, organized system; (3) minimal preparation time is required (4) psychotechno jargon is avoided; and (5) I won't need to spend the next two years training myself and other staff to use the program. Extra points are awarded for extensive field testing.

Using these guidelines, I reviewed a book by Ann Vernon, *Thinking, Feeling, Behaving: An Emotional Education Curriculum for Adolescents*, to determine its usefulness in a psychosocial rehabilitation program and discovered that it met all three of my criteria. The book is based on the principles of Rational Emotive Therapy (RET) introduced by Albert Ellis in the 1960s. Therapy? In a psychosocial program? Although it is based on a therapeutic model, Vernon's book is really a curriculum and is designed to be used in an education setting. Originally intended for school systems, the book contains ninety, 1-2 page lesson plans, divided by grades (7-8, 9-10, 11-12) and is organized into five categories: Self-Acceptance, Feelings, Beliefs and Behavior, Problem Solving and Decision Making, and Interpersonal Relationships. The lessons are sequenced to build on learning from previous lessons. Each lesson plan includes the lesson objective, a list of materials needed, procedures for the stimulus activity and follow-up discussion questions. It also includes a note to the leader about what point to emphasize.

The major strength of Vernon's curriculum is that it is very user friendly. It is well-organized in both the lesson plan format and the sequencing of the lessons. The plans are easy to follow. Each lessons tells you what you need and how to do it. There is nothing complicated about the methodology or the language. It does not require extensive training to lead consumers through any of the lessons.

The curriculum can be used in psychosocial programs, in formally structured classroom settings or in less formal discussion groups. The lessons can be led by staff or member-staff teams. The topics, which include goal setting, signs of stress, personal power, tolerating frustration, resolving relationship issues, are relevant to adults. Lessons would need to be modified, which largely entails changing the situations being discussed from school situations to situations that are more common to clients in psychosocial rehabilitation programs. This is an easy translation which makes them relevant to the participants. After reviewing the book I have begun to incorporate the exercise into some of the work occurring in my own program.

The book does have its limitations. Although the lessons provide for active participation of the learners in the stimulus activity and follow-up discussion, the curriculum is designed to teach concepts and not to measure skill performance. While it has implications for skill training, it does not directly assess improved behavioral functioning as a result of learning these concepts. Using it in a rehabilitative context might require incorporating performance objectives to correspond with the concepts being taught. However, this is a relatively easy modification.

On balance, Vernon's curriculum should prove useful to a broad range of psychosocial programs. It is structured and simple enough to fit numerous models of psychosocial rehabilitation and serve the needs of a large group of consumers. While it is not ideal and forces the practitioner to spend time modifying the material, it is a very helpful starting point for social skills training programs.

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Supervising Counselors and Therapists: A Developmental Approach

Cal D. Stoltenberg and Ursula Delworth. San Francisco: Jossey-Bass Publishers, 1988, 212 pg., $22.95.

As fiscal and human resource shortages increase, administrators of psychosocial rehabilitation programs face new challenges in staff hiring, retention, and development. One such challenge is providing quality supervision which will monitor employee performance of job duties while enhancing the effectiveness of their interactions with clients. Supervisors may be selected based on seniority or clinical skill rather than training or experience as supervisors. Even staff with advanced degrees may have little or no training in how to supervise. Publications for supervisors are often geared towards one theoretical orientation and / or one clinical discipline. This book provides an atheoretical framework for assessing and describing supervisees, and offers some practice suggestions for facilitating the growth and development of new clinicians.

The book is divided into ten chapters. The first two review developmental theories—first, human growth and development, then developmental models of clinical supervision. The next three chapters define the developmental levels of supervisees. The concluding chapters discuss assessing the development of supervisee, how training affects professional development, and implications for supervision research and practice.

The text presents a picture of the developing supervisee, describing changes in each of the various domains of clinical practice. The three overriding structures of development are self- and other-awareness, motivation, and autonomy. This comprehensive list might be improved by separating the concepts of self-awareness and other-awareness, as experience shows that the two do not always go hand in hand. The more specific domains of supervisee development are described as: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment goals and plans, and professional ethics.

Supervisee development is characterized as occurring in three phases. The Level One supervisee focuses primarily on "self," is highly motivated to become an effective helper, and is quite dependent on the supervisor. As the supervisee moves to Level Two, he or she becomes so focused on "other" that each client becomes remarkably unique—so unique that the supervisee resists any suggestions from the supervisor that general principles may apply to this particular person. This new perspective on uniqueness of individuals can be both exciting and paralyzing to the budding clinician. In combination with vacillating needs for dependency and autonomy, the supervisee may feel overwhelmed, and experience some decrease in motivation at times. The Level Three supervisee has achieved a balance between self- and other-awareness, and is beginning to develop a personal clinical style, which decreases dependence on the supervisor. Rarely, one finds a "master therapist" who has achieved Level Three in all of the domains of clinical practice, and is labelled by the authors as "Level Three Integrated."

By describing the levels of supervisees, the authors have identified a valuable language for describing the clinical development of practitioners. This book contributes new guidelines for assessment and training practicies for counselors and therapists. Both of the authors are educators in counseling psychology, and approach their material from the point of view of the trainer / supervisor. Professional training and development is thoroughly discussed, yet may not be relevant to supervisors of paraprofessional staff who struggle to balance task monitoring with clinical supervision.

The authors' efforts to ground their concepts in broad theories of development dilutes the impact of their points. The early chapters provide too much information for readers familiar with developmental theory, and not enough information to educate readers unfamiliar with this field. The book begins and ends with poetry, apparently created by a former supervisee of the authors. This is an interesting technique, but does not enrich the text. Instead, it detracts from the generally objective descriptions, which make up the overall tone of the book.

Recommended for educators and trainers, the book also has some relevance for practicing supervisors. Additionally, some of the concepts may help administrators in developing hiring guidelines by defining what level of practitioner is desired for entry and middle management positions.

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Old Men of the Bowery: Strategies for Survival Among the Homeless

Carl I. Cohen and Jay Sokolovsky. Guilford Press, 1988, 248 pg., $35.00.

As the authors tell us in the Introduction, "Their life pathways point to where today's young homeless will head if meaningful interventions are not introduced." This is an ominous statement since there are more homeless people of every type than there have been since the Great Depression. All those who would concern themselves with the issue of American life quality should *read this book*. It is a basic orientation to homelessness with specific attention paid to elderly men.

The book has ten chapters which follow the lives of three bowery men in an intentionally humanistic manner. The authors then inform us about how these men got to the Bowery and how we might intervene to support their struggles to survive. There is statistical data in Chapter seven concerning the physical and mental health of these old men. I found the chapter on the history of homelessness and the tenth Chapter on intervention most fascinating. In the tenth Chapter we are presented with a clear, scientifically based blueprint to provide services for these older homeless men. The authors cover respite needs, nutrition, health care, psychiatric and alcohol counseling, housing advocacy, financial stabilization, outreach, work and vocational rehabilitation and educational needs. Most of these men are homeless due to poverty and they stay homeless due to poverty. The provision of essential human services to these men can dignify our society and offer these old men a caring response to their attempts to stay alive in an increasingly difficult social environment.

Cohen and Sokolovsky have produced a work of intellectual depth and obvious sensitivity to older homeless men. They appeal to us not to forget about their needs in the face of growing numbers of other homeless people, i.e., women, children and young people.

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This manual is based on the experience of the Committee for Advocacy Through Art in organizing and successfully implementing the exhibition "Art and Mental Illness: New Images" held at Boston University from September 28 through October 24, 1989. The manual is designed to meet the challenge of promoting the creative abilities of the artists while protecting their rights and confidentiality. Although this manual focusses on art by people with mental illness, it can readily be adapted to exhibitions of art by people with or without other disabilities.

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Anyone interested in becoming an IAPSRS member may fill out the request on the opposite page or call (301) 730-7190 for further information.

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Membership in IAPSRS is your best opportunity to connect with the entire psychosocial rehabilitation field and stay on top of issues that are pertinent to its future and success.

ORGANIZATIONAL MEMBERSHIP benefits include—

- Organizational Bulletins
- Public Policy Alerts
- Consultation and technical assistance
- Discounts on Alamo Rent-A-Car, This End Up furniture, Sears major appliances, automobile/van purchases
- Plus, all benefits listed below for Individual and Associate Members

Dues for Organizational membership are based on annual operating budget and range from $85 to $1,500 per year.

INDIVIDUAL MEMBERSHIP is for providers of services, and benefits include—

- *Psychosocial Rehabilitation Journal*
- *IAPSRS Newsletter*
- *Community Support Network News*
- Discounts on IAPSRS publications
- Chapter membership (where organized)
- Participation in IAPSRS national/international and chapter activities

Dues for Individual membership are $70.00 per year.

ASSOCIATE MEMBERSHIP is expressly for non-providers which may include consumers, family members, students or any other interested individual who does not provide psychosocial rehabilitation services. Benefits include—

- *IAPSRS Newsletter*
- *Community Support Network News*
- Member discounts at the National IAPSRS Annual Conference
- *Psychosocial Rehabilitation Journal* subscriptions may be purchased at the discounted rate of $26.00 per year

Dues for Associate membership are $25.00 per year.

Please send me an Organizational____ Individual/Associate____ membership application.

Name:______________________________

Title:______________________________

Agency:______________________________

Address:______________________________

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Telephone #:_______________ Fax #:_______________

Mail to: IAPSRS, 5550 Sterrett Place, Suite 214, Columbia, Maryland 21044

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